99TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPT. 99-241
Part 1

DEFICIT REDUCTION AMENDMENTS OF 1985

JULY 31, 1985.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

together with

DISSENTING AND ADDITIONAL DISSENTING VIEWS

[To accompany H.R. 3128]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means to whom was referred the bill (H.R. 3128) to make changes in spending and revenue provisions for purposes of deficit reduction and program improvement, consistent with the budget process, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

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I. SUMMARY

A. TITLE I—MEDICARE PROVISIONS

(1) *Hospital Rate of Increase.*—The Secretary of HHS would be required to provide a 1% rate of increase to the diagnosis-related group (DRG) payments for fiscal year 1986. A 1% rate of increase

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would be provided to prospective payment system (PPS)-exempt hospitals for fiscal year 1986.

(2) *Disproportionate Share Adjustment.*—The Secretary of HHS would be required to make additional payments to urban PPS hospitals with 100 beds or more serving a disproportionate share of low-income patients. The proxy measure for low-income would be the percentage of a hospital's total patient days attributable to medicaid patients (including medicaid-eligible elderly, i.e., medicare/medicaid crossovers).

The Federal DRG payment would be increased by 7% for each 10 percentage point increase in the proportion of low-income days to total days, above the minimum threshold of 15%. The maximum adjustment would be no greater than 16%. Approximately 850 hospitals would receive some adjustment under this proposal. A limited exceptions process would be established for urban hospitals with 100 beds or more. The Secretary would be required to make disproportionate share payments of 16% per DRG where a hospital can demonstrate that 30% of its inpatient care revenue is provided by local or state governments for patient care for low-income patients not covered by medicaid. The provision would expire in two years. The provision would be effective for discharges on or after October 1, 1985.

(3) *Indirect Teaching Adjustment.*—The indirect teaching adjustment would be reduced to 8.1% for fiscal years 1986 and 1987 on a variable or curvilinear basis. (CBO has estimated that the medicare per resident costs increase at a slower rate as teaching hospitals get larger.) When the disproportionate share provisions expire at the end of fiscal year 1987, the indirect teaching adjustment would rise to 8.7%. The Secretary would be prohibited from changing the manner in which residents' services to inpatients and outpatients are counted for the purposes of determining the indirect teaching adjustment. The provision would be effective for discharges on or after October 1, 1985.

(4) *Hospital Transition to National Payment Rates.*—The 50% hospital specific payment (HSP)/50% Federal DRG rate would be maintained for another year. The transition schedule in current law would continue after fiscal year 1986. The schedule therefore would be: FY 1986: 50% HSP/50% Federal DRG; FY 1987: 25% HSP/75% Federal DRG; FY 1988: 100% Federal DRG.

(5) *Direct Medical Education.*—The Secretary would be prohibited from imposing a one-year freeze on medicare payments for the direct costs of medical education.

(6) *Change the Calculation of the Medicare Part B Premium.*—The temporary provision of law under which enrollee premiums are to produce premium income equal to 25% of program costs for elderly enrollees would be extended for one additional year (1988).

(7) *Physician Fee Freeze Extension.*—On October 1, 1985, any physician who signs a participation agreement effective for the year beginning October 1, 1985, would receive an increase in medicare payments. For any physician who does not sign a participation agreement, the current 15-month freeze on medicare payments would be extended for 12 months, beginning October 1, 1985. The current prohibition on increases in actual charges of all nonparticipating physicians would also be extended for 12 months, beginning

October 1, 1985. Both participating and nonparticipating physicians would be given an increase in medicare payments on October 1, 1986; however, increases for nonparticipating physicians would be lagged one year behind those of participating physicians. A number of incentives for participation were agreed to.

(8) *Physician Payment Arm of PROPAC.*—The Director of the Congressional Office of Technology Assessment would appoint to the Prospective Payment Assessment Commission two additional members to provide representation for rural hospitals and for nurses. In addition, the Director would appoint six new members to comprise a physician payment unit, which would function as a subcommittee of the Commission. The chairman of the Commission would have discretion as to the allocation of other members of the Commission between the physician and hospital subcommittees.

The mission and duties of the physician subcommittee would be to make recommendations regarding medicare physician payment. Its ongoing duties would be to make recommendations regarding adjustments to reasonable charge levels for physician services, and/or structural changes in the medicare physician payment mechanism. The physician subcommittee would advise the Secretary on the development of a fee schedule based on a relative value scale (RVS), to be implemented by October 1, 1987.

(9) *Return on Equity for Proprietary Hospitals.*—Beginning October 1, 1986, return on equity would no longer be a medicare allowable cost for inpatient hospital services and would also be excluded in determining DRG payment rates. Beginning on October 1, 1985, for outpatient departments and all other providers, the rate of return would be reduced to one times the average rate of return on the hospital insurance trust fund.

(10) *Certain Transfers of Ownership.*—Where a State donates a hospital or skilled nursing facility to a nonprofit corporation, the basis for medicare capital-related costs to the new owner will be the lesser of the fair market value or the prior owner's historical cost (net of depreciation).

(11) *Hospital Area Wage Index.*—The Secretary of HHS would be required to implement the new gross wage index effective October 1, 1985. The requirement of retroactive application of the new wage index would be eliminated. The Secretary would be required to study and make a recommendation to the Congress on refining the area wage adjustment to reflect the higher wage costs incurred in core city areas relative to suburban areas of the same metropolitan area.

(12) *Extend the Working Aged Provision.*—The working aged provision would be amended by removing the upper age limit, thereby extending its applicability to people aged 70 and above.

(13) *Hospice Extension.*—The sunset provision of current law would be repealed. The daily payment rates would each be increased by $10.00 a day.

(14) *Responsibilities of Hospitals in Emergency Cases.*—Three new requirements would be established for medicare hospitals and employees, as follows:

a. *Medical Screening.*—Requirement under which every patient who comes to a hospital emergency department for examination or treatment would be provided an appropriate medical screening.

b. *Necessary Stabilizing Treatment.*—Within their capacities, hospital emergency departments must provide appropriate treatment to stabilize patients who have emergency medical conditions or to provide treatment for patients in active labor, and provide for appropriate transfers.

c. *Prohibiting Inappropriate Transfers.*—The transfer of a patient with an unstable emergency medical condition would be prohibited unless (1) the benefits of the transfer outweigh the risks, and (2) the transfer is an appropriate transfer (that includes the transfer of appropriate documents) and is accomplished in an appropriate manner.

d. *Penalty.*—Failure to meet these requirements would subject the hospital to denial of medicare participation, civil monetary penalties, as well as civil enforcement by aggrieved patients. In addition, a responsible physician who knowingly fails to meet these requirements would be subject to criminal penalties up to one year imprisonment and, if the death of a patient directly resulted from such a failure, the physician would be subject to up to five years' imprisonment. These provisions would not preempt stricter state laws.

(15) *Preventive Services Demonstrations.*—The Secretary of HHS would be directed to establish demonstration projects in at least five states, under the auspices of schools of public health, to determine whether and under what conditions it would be cost-effective to include preventive services as a medicare benefit.

(16) *Health Maintenance Organization Technical Amendments.*—Technical amendments relating to health maintenance organizations (HMOs) and competitive medical plans (CMPs) would: a) clarify financial liability for patients hospitalized on the effective date of enrollment/disenrollment; b) make disenrollments effective with the first day of the first month following the month in which the disenrollment request was made; c) require all TEFRA HMO/CMPs to submit all marketing materials to HCFA for approval at least 45 days before issuance. The HMO/CMP could assume approval in the absence of a response from HCFA within the 45-day period; d) require the Secretary to publish the AAPCC annually, no later than September 7. Also, the Secretary would be required to extend for three more years medicare HMO demonstration waivers for three municipal health services HMO projects jointly sponsored by the Robert Wood Johnson Foundation and HHS.

(17) *Technical Corrections.*—Medicare technical corrections relating to the working aged provision and other minor technical corrections.

(18) *Evaluation of Preadmission Certification Programs.*—The Secretary would be required to evaluate the effectiveness of the PRO 100% preadmission certification programs in comparison with programs that require less than 100% preadmission certification, and to consider the extent to which part B carriers or private entities might perform prior approval activities in outpatient and ambulatory settings more efficiently and effectively than PROs. Furthermore, the Secretary would be required to evaluate the feasibility of extending the PRO prior approval activities to outpatient and ambulatory settings. The Secretary would be required to report his findings to Congress by December 1986.

(19) *Medicare's Reimbursement of Assistant Surgeons During Cataract Operations.*—The Secretary would be required to establish national guidelines to prohibit medicare reimbursement for assistant surgeons' charges in connection with routine cataract operations performed on either an inpatient or outpatient basis. The assistant surgeon would be prohibited from billing medicare or the beneficiary for services that did not receive prior approval. The Secretary would have authority to enforce this provision by invoking the penalty provisions that apply with respect to violations of the fee freeze.

(20) *Hospital-Based Physicians.*—On October 1, 1985, participating hospital-based physicians (HBPs) whose compensation-related charges were frozen as part of the general medicare fee freeze would, like other participating physicians, receive increases in their medicare payment based on their actual charges. Participating HBPs would receive increases that reflect charges that they made during the same base period used to update other participating physicians' charges (April 1984–March 1985). Nonparticipating HBPs would receive payments that reflect their charges during April 1984–March 1985, but deflated to approximate 1982 charges. This is the same period on which other nonparticipating physicians' payment is based. On October 1, 1986, participating and nonparticipating physicians.

(21) *Inherent reasonableness.*—In order to prevent arbitrary application of the "inherent reasonableness" clause (already in regulations), the Secretary would be required to promulgate regulations which specify explicitly the criteria of "inherent reasonableness." The Secretary would be directed to correct both excessive and deficient charges in accordance with these regulations.

The Secretary has used the "inherent reasonableness" clause in other areas of medicare reasonable charge reimbursement. The regulations which define "inherent reasonableness" would extend to all part B reasonable charge reimbursement.

(22) *Limit the Late Enrollment Penalty for Medicare Part A.*—The part A premium penalty would be limited to 10% no matter how late an individual enrolled, and the period during which the penalty is paid would be limited to twice the number of years the enrollment was delayed. At the end of this period, the premium would revert to the standard monthly premium in effect at that time.

(23) *End Stage Renal Disease Networks.*—The Secretary would be prohibited from dismantling ESRD networks, and from consolidating their organization and functions with those of any other entity, such as a Peer Review Organization.

(24) *Private Health Insurance Continuation.*—The business tax deduction for a group health plan would be denied any employer who fails to include in the plan a continuation option to (1) a widowed spouse and dependent children, (2) divorced or separated spouse and dependent children, or (3) medicare ineligible spouse and dependent children. A five year continuation option would be available to the above groups after which time they would be offered the right to convert to an individual policy. The coverage would be identical in scope to the coverage provided under the group plan to similarly situated individuals in the group. The in-

sured spouse would be required to pay both employer and employee share of the premium costs, although the employer could assume the employer share. Coverage would be cancelled during the five-year period if the employer stopped offering group health insurance, the insured spouse did not pay the premiums or became covered under another group policy or medicare, or the insured spouse remarried.

(25) *Allow Continued Medicare Waiver for Certain Areas.*—Certain local medicare reimbursement waiver programs now conducted as research projects would be allowed to continue under conditions similar to those provided for States—basically that medicare payments be less than they would be under the prospective payment program.

(26) *Medicare Coverage for Newly Hired State and Local Employees.*—Medicare coverage would be extended to all new State and local government employment. The hospital insurance portion of the FICA tax would be paid by the governmental entities and their employees. Effective date—employees hired on or after January 1, 1986.

(27) *Reimbursement for Rented Durable Medical Equipment.*—New medicare reimbursement limits would be imposed on rented durable medical equipment. During fiscal year 1986, medicare customary and prevailing charges for rented durable medical equipment would be allowed to increase by only one percent. Thereafter, medicare allowable charges for both rented and purchased durable medical equipment would rise no faster than the CPI. Medicare payment for rented equipment would only be made on the basis of mandatory assignment; i.e., the supplier would be required to accept medicare's allowable charge as his full charge and could collect from the beneficiary no more than the applicable deductible and coinsurance.

(28) *Osteopathic Referral Centers.*—Certain osteopathic rural hospitals could qualify for status as rural referral centers under the medicare PPS program if they have at least 3,000 discharges in a year and meet all other requirements for rural referral center status.

(29) *Occupational Therapy Services.*—Medicare coverage would be extended to occupational therapy services provided (a) in skilled nursing facilities (when part A coverage has been exhausted), (b) in clinics, rehabilitation agencies and (c) by therapists in independent practice (subject to the same annual $500 limit on incurred expenses applicable to physical therapy services).

(30) *Prosthetic Lenses.*—Medicare reimbursement for prosthetic lenses would be limited as follows: (a) for cataract eyeglasses, one replacement each year; and (b) for cataract contact lenses, one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year. The Secretary would be required to apply an "inherent reasonableness" test in determining reimbursement amounts for lenses and to determine separately the reasonable charge for the related professional service.

(31) *New Jersey Medicare Reimbursement Waiver.*—The test of whether medicare reimbursement based on New Jersey's State reimbursement control system is no more costly to medicare than

payments under medicare's regular reimbursement system would be applied over a four rather than a three year period.

(32) *Study of Outlier and Transfer Policy on Rural Hospitals.*—The Secretary would be required to review the adequacy of payments under the prospective payment system's polices on outliers and transfers to determine their impact on rural hospitals, with emphasis on those hospitals with less than 100 beds, and to report to Congress findings with recommendations to address these problems by April 1, 1986.

(33) *Medicare Hospital Payment Information.*—The Secretary would be required to provide, on a timely basis, all hospital specific payment information to the Prospective Payment Assessment Commission, to the Congressional Budget Office, and to the Committees with legislative jurisdiction over part A of medicare. The provider specific information would remain confidential and would be used for analysis of the impact of the PPS system on a state by state basis, SMSA or other basis.

Proposed Report Language

Medicare Hearing and Appeals Process.—The Committee Report would indicate that the Committee believes that the current hearing and appeal procedures under both parts A and B of medicare need to be reviewed. The Committee wants to ensure that adequate procedural safeguards are provided to program beneficiaries, suppliers and providers. The Committee intends therefore, to hold hearings on this issue in the near future and, if it is warranted, to take legislative action.

Physical Therapists.—The Committee Report would indicate that the Committee believes that the requirement that independently practicing physical therapists who operate exclusively in beneficiaries' homes maintain fully-equipped offices is unnecessary. The Committee therefore intends that the Secretary eliminate this regulatory requirement.

The Committee Report would indicate that the Committee expects the Secretary to report to Congress, with recommendations on the appropriateness and feasibility of allowing health care providers (other than a physician or registered nurse that are allowed under current law) to perform the supervisory role for a home health agency. The report would be due April 1, 1986.

(B) TITLE II—TRADE PROVISIONS

(1) *Trade Adjustment Assistance.*—The Committee approved H.R. 1926, as amended and reported by the subcommittee on Trade on July 19, 1985, without further amendments. The amended bill reauthorizes TAA for workers and firms for 4 years until September 30, 1989. Amendments extend coverage to workers laid off from firms relocated overseas and to firms with production/sales losses in significant product lines; extend the collection period for worker benefits and liberalize prior employment requirements; remove matching share requirements for certain firm assistance; and improve program administration.

(2) *Customs, ITC and USTR Authorization.*—The Committee approved the substance of H.R. 2250 as reported by the Subcommittee

on Trade with a minor technical amendment. This authorization would restore the Administration's proposed cut of 887 positions and add an additional 800 front-line Customs personnel. It is expected that the enhanced enforcement capability resulting from the additional personnel will result in a net increase in Customs revenues of about $1.15 billion over a 3-year period.

(3) *Customs User Fees.*—The Committee approved the user fee concept in H.R. 3034, as reported by the Subcommittee on Trade, with amendments. As amended, fees would be assessed on the arrival of commericial vessels over 100 tons ($425), trucks ($5), trains ($5 per car), private yachts, boats, and general aviation ($25 per year) and on passengers arriving on commerical aircraft, trains and vessels ($1 for contiguous countries, U.S. territories and adjacent islands and $5 for all other countries). The receipts from all reimbursable charges would be deposited in the Treasury as micsellaneous receipts and placed in a proprietory account. It is expected that this proposal will result in increased revenues of over $650 million over the 3-year life of the provisions.

C. TITLE III—AID TO FAMILIES WITH DEPENDENT CHILDREN PROVISIONS

(1) *AFDC Quality Control.*—Minimum quality control policies and procedures would be established in statute as would a new national error rate standard of 3.5 percent. Adjustments to the standard would be made if the state operated an AFDC unemployed parents program, exceeded the national average in terms of percent of total stater AFDC caseload with earnings and/or exceeded the national average in terms of population density.

Two adjustments would be made in the raw error rate data collected. First, technical errors would be excluded for fiscal sanctions purposes. Second, the point estimate of a state's error rate would be the lower bound of the range within which a state's true error rate falls, rather than the midpoint, if the state has a sample size sufficient to produce a lower limit of 2.5 percentage points or less than the midpoint. In the calculation of the lower confidence level, the Secretary would have the authority to promulgate regulations to adjust for variability among states in the number, proportion or dollar value of cases where the findings of the state quality control review differ from the Federal findings.

Fiscal sanctions would be imposed on the basis of the adusted error rate and the adjusted state tolerance level. A sanction amount would be reduced by the Federal share of overpayments collected by the state in the fiscal year to which the error rate applies. In addition, the current authority for the HHS Secretary to waive sanctions under certain circumstances would be retained and expanded as proposed in H.R. 1279. The Committee deleted the Subcommittee provision which would have required the Federal government to reimburse states for errors it makes it administering the SSI program.

(2) *Teenage Pregnancy Block Grant.*—The Committee authorized a two-year grant program to permit the state AFDC agency to operate a two-part teenage pregnancy program:

(i) *Prevention Program for AFDC Families:*—These activities would be targeted to male and female children in AFDC fami-

lies and would include active parent participation. The program would address factors which have been shown to play important roles in determining teenage sexual activity and contraceptive use.

(ii) *Comprehensive Service Program or Teenage AFDC Parents.*—Participation would be vountary; teenage parents who elect to participate would be required to seek a high school degree (or equivalent) and would receive services, including training, day care and transportation, to help them become self-sufficient and avoid long-term welfare dependence.

The program activities would be financed through a block grant to each state. The legislation authorizes the appropriation of $50 million in fiscal year 1986 and $100 million in fiscal year 1987. States would be entitled to receive a grant in each of the two fiscal years for which the program is authorized.

(3) *AFDC for Unemployed Two-Parent Families.*—Effective October 1, 1986, the current optional AFDC program for unemployed parents would be mandatory in all states. As a result, all states would aid needy two-parent families in which the principal earner is unemployed.

In addition, the definition of "quarters of work" would be modified to permit, at state option, the substitution of participation in school or training as follows: (1) school attendance would be limited to elementary or secondary school; (2) four quarters of vocational training could be substituted for four quarters of work; (3) attendance in school or vocational training would have to have been full-time; and (4) at least two of the six quarters must be quarters of work.

D. TITLE IV—RAILROAD UNEMPLOYMENT COMPENSATION AND OTHER UNEMPLOYMENT COMPENSATION PROVISIONS

(1) *Railroad Unemployment Compensation.*—The railroad unemployment repayment tax, which is designed to repay loans from the railroad retirement account to the railroad unemployment insurance account and scheduled to begin on July 1, 1986, is increased. The increase amounts to approximately $200 million. The Committee also extended the authority of the unemployment account to borrow from the retirement account. An automatic surcharge of 3.5 percent is imposed in the event of such borrowing.

(2) *Federal Supplemental Compensation.*—The Committee bill allows unemployed individuals who lost FSC benefits because of service in the National Guard during a major disaster to receive such benefits.

E. TITLE V—REVENUE PROVISIONS

The revenue title of the bill includes five provisions, relating to: (1) Internal Revenue Service (IRS) budget for fiscal year 1986; (2) cigarette excise tax; (3) coal excise tax for the Black Lung Disability Trust Fund; (4) tax treatment of Railroad Retirement benefits; and (5) Pension Benefit Guaranty Corporation (PBGC) premiums. The first four provisions are estimated to increase net fiscal year budget receipts by $7.0 billion for the three-year period, 1986–1988.

The increase in PBGC premiums will reduce budget outlays by $612 million over the three fiscal years.

1. *IRS budget for fiscal year 1986*

The bill endorses the increase in the 1986 fiscal year budget for the IRS as approved by the House Committee on Appropriations (H.R. 3036). H.R. 3036 increases the IRS 1986 fiscal year budget by $178 million over the President's budget proposal.

2. *Cigarette excise tax rate extension*

The bill makes permanent the present law cigarette excise tax rates (e.g., 16 cents per pack of small cigarettes), thus extending the current rates beyond September 30, 1985. In addition, the bill allocates the equivalent of one cent per pack of small cigarettes to a new Tobacco Equalization Trust Fund for a 5-year period, October 1, 1985-September 30, 1990. This transfer of cigarette tax revenue is to supplement the funding provided by growers or from other fees for the tobacco price support program.

3. *Coal excise tax for Black Lung Disability Trust Fund*

The bill provides for an increase in the coal excise tax for funding the Black Lung Disability Trust Fund, beginning January 1, 1986, with the following per-ton rates (and price ceilings):

Calendar year(s)	Underground coal tax (per ton)	Surface Coal Tax (per ton)	Price ceiling (percent)
1985 (present law)	$1.00	$0.50	4.0
1986–90	1.50	.75	6.0
1991–95	1.60	.80	6.4
1996	1.50	.75	6.0

The present law rates will be reinstated for any calendar year after 1995 if for the two most recent fiscal years there was no balance of repayable advances to the Trust Fund and no unpaid interest on such advances.

4. Tax treatment of Railroad Retirement benefits

Under the bill, Railroad Retirement disability benefits payable to individuals not entitled to social security disability benefits or in excess of the social security disability benefits which an individual would be entitled generally will be fully taxable. Similarly, Railroad Retirement benefits that are payable at an age earlier than social security benefits or in an amount greater than social security benefits will be fully taxable.

5. Pension Benefit Guaranty Corporation premiums

The bill increases the annual per-participant premium for single-employer pension plans from $2.60 to $8.00, for the period January 1, 1986–December 31, 1988.

SUMMARY OF DEFICIT REDUCTION

The total deficit reduction achieved by the provisions summarized above, over the three-year period from 1986 to 1988, is $19.1 billion, as shown in the following table. The deficit reduction target for the Committee on Ways and Means in the House-passed budget resolution, counting revenue from Superfund legislation which has yet to be considered by the Committee, is $21.5 billion. The committee expects to act on Superfund legislation after the August recess.

Deficit reduction achieved from fiscal year 1986–88

	Billions
Medicare[1]	$10.3
Trade[1]	1.8
Public Assistance and Unemployment Compensation[1]	[2] .4
Pension Benefit Guaranty Corporation Premium Increase	.6
Revenue Proposals	7.0
Total	19.2

[1] Also includes some revenue items.
[2] Number indicates an increase in outlays.

II. Explanation of Provisions

TITLE I—MEDICARE AMENDMENTS

A. Changes Relating Primarily to Part A of the Medicare Program

1. Rate of increase in payments for inpatient hospital services (sec. 101 of the bill)

Present law.—Current law provides that the medicare prospective payment rates should be updated annually by the Secretary of Health and Human Services. The law states that the update should reflect increases in hospital input prices but, for FY 1986, may not exceed the market basket (hospital input prices) plus one quarter of a percentage point.

The Secretary of HHS promulgated proposed regulations that would freeze DRG payments for FY 1986 at the FY 1985 levels. This regulatory initiative would save $6.420 billion over three years.

Explanation of provision.—The bill would require that the Secretary provide a 1% increase to the DRG payments. A similar rate of increase would be provided for PPS exempt hospitals which remain on a cost reimbursement system.

The Committee, in deciding to provide for a 1% increase, has taken into consideration the errors made when the prospective payment rates were first established. The Congress required the Secretary to use the most recent available information when establishing the prospective payment rates in 1983. In complying with this requirement the Secretary used unaudited cost data in developing the PPS rates. The General Accounting Office has since determined that the unaudited 1981 cost reports overstated the actual costs incurred by hospitals in the base year by 4.39%.

Effective date.—The provisions would be effective for cost-reporting periods beginning during fiscal year 1986 for prospective pay-

ment system-exempt hospitals; and for discharges occurring during fiscal year 1986 for prospective payment system hospitals.

2. One-year extension of DRG transition (Sec. 102 of the bill)

Present law.—The Social Security Amendments of 1983 (P.L. 98-21) provided for a new prospective payment system for hospital inpatient services provided to medicare beneficiaries.

Current law provides for a three-year phase-in or transition from hospital specific to national DRG (diagnosis-related group) rates. During this period a declining portion of each hospital's total prospective payment will consist of a hospital-specific payment (HSP), based on its historical reasonable costs, and an increasing portion will be based on a combination of regional and national DRG rates. In the fourth year of the program and thereafter, medicare payments will be determined under a totally national DRG payment methodology. The change in the historical cost/Federal DRG payments are made on a hospital's cost reporting period basis.

The Federal DRG component is comprised, for the first three years, of a combination of Federal and regionally determined rates. This phase-in recognizes the historical differences in hospital costs among regions of the country. Thus, different regional payment levels are provided for nine census divisions of the United States. Changes in the regional/national component of the Federal DRG are made on the Federal fiscal year basis.

The DRG payment rate phase-in started with each hospital's first cost reporting period which began on or after October 1, 1983. Below is the transition schedule under current law:

For hospital cost reporting periods beginning on or after:

10/1/83—75% HSP/25% DRG (100% regional);
10/1/84—50% HSP/50% (75% regional/25% national);
10/1/85—25% HSP/75% DRG (50% regional/50% national);
10/1/86—100% DRG (100% national).

Explanation of provision.—The bill would extend the transition period for one additional year. The 50% hospital specific cost/50% Federal DRG blend would be maintained for FY 1986. The schedule would therefore be:

For hospital cost reporting periods beginning on or after:

10/1/84—50% HSP/50% DRG (75% regional/25% national);
10/1/85—50% HSP/50% DRG (75% regional/25% national);
10/1/86—25% HSP/75% DRG (50% regional/50% national);
10/1/87—100% DRG (100% national).

The prospective payment system is phased-in over a three-year period to give hospitals time to make adjustments to the new PPS system. Under the PPS system, hospitals with costs in excess of the medicare payment are forced to absorb the loss, while hospitals with costs below the medicare payment are permitted to keep the savings.

This provision would have two effects. First, it would continue, for one more year, to base 50% of the payment on the hospital's own historical costs. Second, it would continue, for one more year, to base 75% of the payment on regional costs.

The Committee believes that this additional transition year would give all hospitals more time to adjust to the prospective payment system. In addition, it would provide hospitals in higher cost

regions of the country an opportunity to make the necessary changes to reduce their costs.

The Committee is committed to the prospective payment system under medicare. This one-year delay in the transition to national rates does not reflect a lack of support for the prospective payment system but rather a concern that the three-year transition from cost reimbursement to national DRG rates is an inadequate period of time for higher cost hospitals, especially in higher cost regions of the country, to reduce their costs to the national average.

Furthermore, the Committee expects that over the next year significant progress will be made in developing refinements to the DRG system to more accurately reflect the actual costs incurred in providing care. For example, the Committee, in this legislation, has requested a report on refining the hospital wage index to reflect the higher costs incurred in core city areas relative to suburban areas. In addition, the Committee anticipates that significant progress will be made toward implementing a severity of illness index.

Effective date.—For the Federal DRG portion (i.e. retaining the 75/25 regional/national component for one more year), the provision would be effective for discharges occurring in Federal fiscal year 1986. For the hospital specific/DRG component (i.e. retaining the 50/50 HSP/DRG payment) the provision would be effective for hospital cost reporting periods beginning on or after October 1, 1985.

3. Application of revised hospital wage index (sec. 103 of the bill)

Present law.—As an integral part of the medicare prospective payment system (PPS) for hospitals, the Federal portion of the prospective payment rates is adjusted to take into account differences in wages from area to area. This is accomplished by means of an area wage index applied to all PPS hospitals in urban and rural areas. The current hospital wage index is constructed from a national data base of hospital wage records maintained by the Bureau of Labor Statistics (BLS). There are a number of technical flaws in this index, principally that it fails to recognize local differences in the number of part-time workers hospitals employ.

Because of inaccuracies in the BLS wage index, the Secretary was required to report to Congress on a refined area wage index. The report outlined two alternative wage indices based upon a survey of over 5,000 hospitals. The Department of Health and Human Services has included in its proposed PPS regulations for the coming fiscal year the adoption of one of these indices, the "gross hospital wage index." This index is derived from total gross hospital wages, including salaries of interns and residents, hospital-based physicians, and all other wages and salaries paid to hospital employees.

Present law specifies that any new wage index be implemented retroactively to October 1, 1983.

Explanation of provision.—The bill would require the Secretary to implement the new gross wage index promulgated in the proposed regulations published June 10, 1985, effective for October 1, 1985. The present law requirement of retroactive application of the new wage index would be repealed. The bill would require that the

gross wage index be used for discharges occurring during FY 1986. The Committee intends to give the Secretary flexibility to make further refinements in the area wage index for FY 1987 and beyond.

By requiring that the hospital wage gross index, as described in the proposed regulations of June 10, 1985, be adopted, the Committee does not wish to preclude the Secretary from making adjustments to reflect computational errors that may have been made in calculating the specific index amounts.

The Secretary would be required to study and report to the Congress recommendations on refining the area wage adjustment to reflect the higher wage costs incurred by central city areas relative to suburban areas of the same metropolitan area.

Effective date.—The bill would be effective for discharges occurring during FY 1986 and thereafter.

4. Change in formula for indirect teaching adjustment (sec. 104 of the bill)

Present law.—The medicare program has always provided reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents and teachers and classroom costs) are excluded from the prospective payment system, and are reimbursed on a reasonable cost basis. The indirect costs are increased patient care costs associated with teaching programs due to such factors as increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios and a more severely ill patient population.

These indirect costs have been estimated statistically for the purposes of adjusting medicare payments on a prospective basis. The increases in payments vary directly with each hospital's ratio of interns and residents to its number of beds (IRB). Specifically, the Health Care Financing Administration has estimated, on a linear basis, that a 0.1% increase in IRB ratio would result in a 5.79% increase in medicare's cost per discharge.

When Congress passed the prospective payment system it established the indirect teaching adjustment factor at 11.59%—double the original estimate. This adjustment is made to the Federal DRG portion only. The adjustment was doubled because, in aggregate, teaching hospitals received lower payments under the DRG system than under the cost-based system. Additional concern that the DRG system would adversely affect teaching hospitals stemmed from doubts about the ability of the DRG case classification system to fully account for factors such as severity of illness, urban location, bed size and increased medicare costs associated with hospitals that serve large numbers of low-income patients. The doubling of the indirect teaching adjustment from 5.79% to 11.59% was done on a budget-neutral basis. The DRG payments were adjusted downwards overall to account for the doubling of the indirect teaching adjustment.

The Administration's FY 1986 budget includes a provision which would reduce the indirect teaching adjustment by half, to 5.79%. This would save $2.9 billion over three years.

Explanation of provision.—The provision would reduce the indirect teaching adjustment to 8.1% (for FY 1986 and FY 1987) and 8.7% (for FY 1988 and beyond) for each 0.1 increase in the IRB ratio on a variable basis. The data reviewed by the Committee show clearly that the 11.59% indirect teaching adjustment is too high, and that the appropriate adjustment is 8.7%. Also, CBO has estimated that medicare costs increase at a slower rate as teaching programs get larger. Therefore, the current method of using a constant adjustment for each 0.1 increment in the IRB ratio may over compensate those hospitals with the highest IRB ratios. CBO estimates indicate that an adjustment made on a variable basis would better reflect the non-linear cost relationship. Therefore, the Committee bill provides for a curvilinear adjustment.

The Committee has also approved an adjustment to hospitals serving a disproprionate share of low-income patients for fiscal years 1986 and 1987. The data reviewed by the Committee support a lower indirect teaching adjustment if a disproportionate share adjustment is provided. The lowering from 8.7% to 8.1% recognizes that a portion of the indirect teaching adjustment compensates hospitals serving a disproporionate share of low-income patients. When the disproportionate share provisions expire at the end of FY 1987 the indirect teaching adjustment would revert to 8.7%.

The savings from the reduction in the indirect teaching adjustment from 11.59% on linear basis to 8.7% on a curvilinear basis would be total systems savings taking into account variations in indirect teaching payments across regions. The savings from the further reduction from 8.7% to 8.1% would be retained in the payment pool to offset the additional costs of the disproportionate share provision.

The Committee has stated the specific indirect teaching adjustment formula in the law. There is no discretion on the part of the Secretary. Furthermore, the Committee bill requires that the Secretary continue to count, for purposes of establishing the IRB ratio, those interns and residents who serve in the outpatient departments of hospitals. This would prohibit the Secretary from implementing the change in counting promulgated in proposed regulations published June 10, 1985. The change proposed by the Administration on the IRB count are technically incorrect because the regression analysis used to compute the adjustment factor was based on counts that included the interns and residents in hospital-based outpatient settings.

Effective date.—The provision would be effective for discharges occuring on or after October 1, 1985.

5. Computation of additional payment amounts for hospitals serving a disproportionate share of low-income patients (Sec. 105 of the bill)

Present law.—Under the Social Security Amendments of 1983 the Secretary of HHS was required to make such adjustments to the PPS rates as the Secretary deems appropriate for hospitals that serve a disproportionate number of low-income or medicare patients. The Deficit Reduction Act of 1984 also required the Secretary, prior to December 1, 1984, to develop and publish a definition of disproportionate share hospitals, to identify such hospitals, and

to make the list available to the Committees with legislative jurisdiction over part A of medicare. The Secretary has to date failed to develop criteria for defining or identifying such hospitals or otherwise make information available to the Committees.

Explanation of provision.—The bill would require the Secretary of HHS to make additional payments on the Federal portion of the DRG payment, for urban PPS hospitals with 100 beds or more, serving a disproportionate share of low-income patients. The proxy measure for low-income would be the percentage of a hospital's total patient days attributable to medicaid patients (incuding medicaid-eligible medicare beneficiaries—medicare/medicaid crossovers). The Federal DRG payment would be increased by .7 percent for each 1 percentage point increase in the ratio of low-income inpatient days to total inpatient days, above the minimum threshold of 15%. The maximum adjustment would be no greater than 16%.

A limited exceptions process would be established for urban PPS hospitals with 100 beds or more. The Secretary would be required to make disproportionate share payments where a hospital can demonstrate that at least 30% of its net inpatient care revenue is provided by local or state governments for inpatient care for low-income patients not otherwise reimbursed by medicaid. If this threshold is met the per DRG add-on would be 16%.

Despite several mandates in the law, the Secretary continues to fail to implement a disproportionate share adjustment in any meaningful way. This total lack of responsiveness on the part of the Secretary has forced the Committee to go to the considerable length of mandating a specific adjustment to the PPS system to provide additional payments to disproportionate share hospitals. The Committee's concern for disproportionate share hospitals has increased as the PPS system continues to phase in. The Prospective Payment Assessment Commission also views this adjustment as a high priority for implementation in FY 1986. Considering all these facts, the Committee decided to proceed to develop an adjustment based upon the best available information. The Committee felt that any reasonable adjustment that could be implemented in FY 1986 would be better than none.

Hospitals that serve a disproportionate share of low-income patients have higher medicare costs per case. There are two categories of reasons for these increased costs: a) low-income medicare patients are in poorer health within a given DRG (that is, they are more severely ill than average), tend to have more complications, secondary diagnoses and fewer alternatives for out of hospital convalescence than other patients; b) hospitals having a large share of low-income patients (medicare and non-medicare) have extra overhead costs and higher staffing ratios which reflect the special need for such personnel as medical social workers, translators, nutritional and health education workers. These hospitals are frequently located in central city areas and have higher security costs. They often serve as regional centers and have high standby costs for trauma units, burn units, psychiatric emergency services, neonatal intensive care units and poison control units. They are often recipients of economic transfers of high cost low-income patients from other hospitals.

The conclusion that certain hospitals serving a disproportionate share of low-income patients have higher costs per case is supported by data and analysis from the Congressional Budget Office, the Prospective Payment Assessment Commission, the Health Care Financing Administration, the American Hospital Association and the Urban Institute.

Based on comprehensive analysis of cost data, the Committee determined that the only hospitals that demonstrated a higher medicare cost per case associated with disproportionate share of low-income patients were urban hospitals with over 100 beds. The Committee carefully reviewed all the information relating to rural hospitals. Based on all the data available to the Committee, there was no evidence to indicate that medicare costs per case were higher in rural hospitals serving a disproportionate share of low-income patients. Since the rationale for making the disproportionate share adjustment is related directly to higher medicare costs per case, the Committee concluded that, based on available data, there was no justification for making these payments to rural hospitals, or to urban hospitals with fewer than 100 beds.

The Committee has explicitly required that the Secretary make additional payments for disproportionate share urban hospitals with over 100 beds for discharges occurring in FY 1986 and FY 1987. There is no discretion on the part of the Secretary.

In developing the adjustment, the Committee searched for a proxy measure for low income. The Committee reviewed available information from the American Hospital Association and other sources and determined, after extensive review, that use of the medicaid days as a proxy most accurately reflected the factor the Committee was trying to measure, the presence of low-income patients. The Committee did not want to impose any additional administrative requirements on hospitals or patients. Therefore, the Committee rejected any direct measures of the income of patients. Furthermore, the proxy measure chosen can easily be implemented for FY 1986.

The Federal DRG payment would be increased by .7% for each one percentage point increase in the ratio of low-income inpatient days to total inpatient days, above a minimum threshold of 15%. If a patient is eligible for medicaid at any point during his inpatient stay, all days of care attributable to that patient would be counted under the provision, whether or not actually paid for by the medicaid program. In no case would a hospital receive an adjustment greater than 16%. If a Hospital qualified for the maximum under this provision or under the exception provision described below, the per DRG payment would be increased by 16%.

The Committee provided for a sunset of the disproportionate share provision after two years. In providing for the sunset the Committee anticipates that refinements in the PPS system would be implemented that would limit the need for such a disproportionate share adjustment; examples of such refinements might be a refined area wage index to reflect the higher wage costs of central city areas relative to suburban areas and an adjustment for severity of illness.

The indirect teaching adjustment in this bill was reduced from 8.7% to 8.1% to reflect the disproportionate share adjustment.

When the disproportionate share adjustment expires in two years, the indirect teaching adjustment would be increased for FY 1988 and beyond to 8.7%.

The Committee believes that the Secretary should interpret the 100-bed threshold narrowly, that is, that the beds that should be counted should be staffed and available beds. The bed count would reflect beds staffed and available in the cost reporting period immediately prior to the cost reporting period for which the adjustment would be made.

The disproportionate share provision would be budget neutral. Both the indirect teaching adjustment and the disproportionate share provision require a restandardization of the standardized payment amounts. In order to ensure that the budget neutrality calculation does not redistribute payment amounts among the twenty payment areas for which standardized payment amounts are calculated, the budget neutrality adjustment should be calculated to take into account the varying teaching payments in each of these regions. For each of these twenty payment areas, indirect teaching payments based on rates standardized to 8.1% curvilinear and paid out on the same basis plus the disproportionate share payments, shall be neither more nor less than the payments based on rates standardized by 11.59% linear indirect medical education factor and paid out on 8.7% curvilinear basis. It is the intent of the Committee that the term "budget neutral" as applicable to this provision for FY 1986 and 1987 implies that total payments should be no more and no less than would have occurred if the only change were to reduce the indirect teaching adjustment to 8.7 percent on a curvilinear basis. That is, the reduction in the indirect teaching adjustment from 8.7 percent to 8.1 percent must be used to partially offset the cost of the disproportionate share adjustment. The remaining disproportionate share cost would be reflected in lower standardized amounts.

Because of concern that this proxy measure of low-income status might substantially understate the presence of low-income patients in some hospitals, most particularly public hospitals in states where the medicaid eligibility standards are stringent, this provision also includes a limited exceptions process for such hospitals. This exceptions process would require the Secretary to make disproportionate share payments of 16% per DRG on the Federal portion where the hospital can demonstrate that 30% or more of its net inpatient care revenue is provided directly or indirectly by local or State governments for inpatient care not otherwise reimbursed by medicaid. Hospitals account for their State and local inpatient care appropriations in various ways. Some hospitals receive patient-specific payments in addition to more general direct or indirect subsidies. The Secretary would be required to include all such inpatient care payments in determining whether a hospital meets the threshold for the exception. The Committee does not intend for hospitals to include appropriations not related to inpatient care operating costs. The Committee further intends that the denominator of this equation, net inpatient care revenue, be defined according to the generally accepted accounting principles in the hospital industry; i.e., this factor should represent gross patient care revenues

less deductions from revenue (other than contractural allowances), as those terms are generally used.

The Committee believes that the exceptions process is very limited and the Secretary should ascribe relatively small costs to be associated with the exceptions process. Since the adjustment is on a budget-neutral basis, any over-estimate of the cost of the exceptions process will result in lower standardized payment amounts.

The Committee anticipates that the disproportionate share payments would be paid to hospitals on an interim payment basis with settlement at the end of the hospital's cost reporting period. This is the same method other payments are made under the medicare program.

The Committee understands that to implement the indirect teaching adjustment, the disproportionate share adjustment and the new wage index may require the use of data from different time periods.

Effective date.—Discharges occurring between October 1, 1985 and September 30, 1987.

6. Treatment of certain rural osteopathic hospitals as rural referral centers (sec. 106 of the bill)

Present law.—Under present law, rural hospitals that meet certain requirements can qualify to receive the "urban" standardized payment amount adjusted by the rural wage index that applies for the geographic area. The adjustment was permitted because data indicated that large rural hospitals with high case-mix indices had cost experiences similar to those experienced by urban hospitals.

In order to qualify as a rural referral center under current regulations, a hospital must have or exceed a specified minimum case-mix index, have at least 6,000 discharges in a cost-reporting period and meet other requirements. Under these criteria, approximately 146 rural hospitals qualify as rural referral centers. The Health Care Financing Administration reviews each rural referral center every three years to determine whether the hospital continues to qualify.

Explanation of provision.—The bill would allow osteopathic hospitals to qualify as rural referral centers if they have at least 3,000 discharges in a cost-reporting period and meet all the other requirements, as specified by the Secretary, for rural referral center designation.

Effective date.—Effective for cost reporting periods beginning on or after the date of enactment.

7. One-year prohibition on freezing cost increases that may be recognized for direct medical education (sec. 107 of the bill)

Present law.—Medicare has historically reimbursed teaching hospitals on a cost basis for its share of the direct costs of approved medical education activities.

On July 5 of this year, the Administration issued final regulations freezing the amount medicare will reimburse providers for their direct costs of approved medical education activities, for cost reporting periods beginning on or after July 1, 1985.

The freeze permits payment based on the lesser of a provider's allowable direct medical education costs for the current cost report-

ing period or for a base year (the provider's cost reporting period beginning on or after October 1, 1983), adjusted for changes in medicare utilization.

Explanation of provision.—The Committee bill would prohibit the Secretary from implementing the regulations that impose the one-year freeze on medicare payment for the direct costs of approved medical education activities.

The Committee views the freeze as a regulatory action driven by budgetary considerations which are not within the scope of factors the Secretary may consider in making reasonable cost determinations.

The Committee recognizes a need to re-examine Federal policy regarding support of medical education programs through the medicare trust funds, and may wish to legislate in this area next year.

Effective date.—The provision would be effective retroactively to July 1, 1985.

8. Return on equity capital for inpatient hospital services and other services (sec. 108 of the bill)

Present law.—A return on equity (owner) capital invested and used in providing patient care is considered a medicare allowable cost for proprietary, or for-profit, health care providers. Equity capital is the net worth of a hospital excluding those assets and libilities not related to patient care. Specifically, equity capital includes: (1) the investment in the plant, property, and equipment (net of depreciation) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital maintained for necessary and proper operation of patient care facilities.

The level of payment for return on equity (ROE) formerly was set at a rate of no more than one and one-half times the average rate of return on trust fund investments. In the 1983 social security amendments, the Congress reduced the level of payment for ROE with respect to reasonable costs of inpatient hospital services to the average rate of return on trust fund investments. The rate of return for other provider services was not affected.

Explanation of provision.—Beginning October 1, 1986, return on equity would no longer be a medicare allowable cost for inpatent hospital services. In addition, costs attributable to a return on equity capital would not be include in determining national and regional adjusted DRG prospective payment rates.

The Committee believes that under the prospective payment system hospitals should earn rather than be guaranteed a profit (or surplus). Hospitals that operate efficiently and economically can earn a profit under the prospective payment system and do not need a medicare-guaranteed return on equity. Further, the Committee believes that the prospective payment system's recognition of capital-related costs should be applied evenly to all hospitals. Return on equity capital for proprietary hospitals should not be included.

Beginning October 1, 1985, the bill would reduce the rate of return for other provider services, if regulations provide for ROE, to the average rate of return on the hospital insurance trust fund.

Effective date.—For inpatient hospital services, the provision would be applicable to cost reporting periods beginning on or after

October 1, 1986 and to DRG payments for discharges on or after October 1, 1986.

For other provider services, the provision would be applicable to cost reporting periods beginning on or after October 1, 1985.

9. Continuation of medicare reimbursement waivers for certain hospitals subject to regional hospital reimbursement demonstrations (sec. 109 of the bill)

Present law.—Under present law, normal medicare reimbursement rules may be waived for demonstration projects. When research is completed, the normal medicare reimbursement rules are reinstated.

Explanation of provision.—The bill would allow a local hospital reimbursement control system that had operated under a medicare waiver to continue if the State requests the continuation and if the local project meets condition imposed Statewide on States that receive a waiver.

Such a system would be required to include substantially all acute care hospitals in its area and review at least 75 percent of all revenues or expenses in that area for inpatient hospital expenses and 75 percent of revenues or expenses in the area for inpatient hospital services provided under the State's plan approved under title XIX. Medicare's costs could not exceed what they otherwise would be under the medicare PPS system.

This option would be available only to reimbursement systems that were carrying out a demonstration on January 1, 1985 and had been approved by the Secretary of Health and Human Services. The Committee's provision reflects the view that hospital reimbursement control systems, such as that operating in the Rochester, New York area, that began as research-oriented demonstration projects, should be allowed a continued waiver if they achieve the requisite savings.

Effective date.—The provision would be effective upon enactment.

10. Four-year test for state waivers for certain states (Sec. 110 of the bill)

Present law.—Under present law states may request a waiver of medicare's reimbursement rules for a statewide hospital reimbursement control system under Section 1886(c) of the Social Security Act. A number of requirements must be met before such a waiver request is granted. One requirement is that the State demonstrate, to the Secretary of HHS's satisfaction, that the amounts of payments made under the waiver would not exceed the amounts that otherwise would have been paid with respect to a 36-month period under Title XVIII if the state were not under a statewide reimbursement waiver.

Explanation of provision.—The provision would extend the 36-month test period under section 1886(c)(1)(C) for a further 12 months. Therefore the comparison period would be a 48-month period. The provision would apply only to States which had made a request for a waiver under 1886(c) prior to December 31, 1984. The only state that meets these criteria is New Jersey.

The Committee has repeatedly reaffirmed the value of State reimbursement control systems. In the Social Security Amendments of 1983, the Secretary was required to approve State applications for statewide alternative payment systems, as long as they meet certain conditions. The key condition, expressed in Section 1886(c)(1)(C), is a cost-effective test—the State must be able to assure the Secretary that medicare payments under the State system are projected for a 36-month period to be no greater than they would be using medicare's own rules.

The Committee does not intend that its action in delaying the DRG transition in the prospective payment system should jeopardize these systems. Specifically, the Committee wants to avoid the situation in which the delay in the transition changes the calculation of what medicare would otherwise pay to such an extent that an otherwise effective State reimbursement control system becomes unable to meet the cost-effectiveness test during the current 36-month period.

The Committee's amendment would add a fourth year to the cost-effectiveness test for certain State systems approved under Section 1886(c). The Secretary is directed not to terminate any approved system, for failure to meet the cost-effectiveness criteria, so long as the State takes appropriate steps by July 1, 1986, to assure the Secretary that its system will continue to meet the cost-effectiveness test, applied over a 48-month period.

The Committee also expects the Secretary to continue monitoring payments and other oversight programs as set forth in the waiver agreements to ensure that systems comply with all statutory standards and other agreed-to terms and conditions, except that the monitoring plan may be revised to reflect the revision of data submitted, as a basis to assure the Secretary that the cost-effectiveness requirements, as modified, are met.

Effective date.—The provision would be effective upon enactment.

11. Special rule for treatment of depreciation and capital indebtedness for donations of state property to non-profit corporations (sec. 111 of the bill)

Present law.—Section 2314 of the Deficit Reduction Act limited the basis for which medicare depreciation is allowed when a change of ownership occurs. The new owner basis is the lesser of (1) historical cost (cost to the original owner) or (2) the purchase price.

Explanation of provision.—The bill would provide a special rule for treatment of certain transfers. In the case of an asset that is donated by a State government (donor) to a non-profit corporation (donee) the basis from which capital-related costs to the donee is calculated would be the lesser of the donor's historical cost (net of depreciation) or the fair market value.

The Committee was concerned that donated assets would be subject to the limitation enacted in DEFRA. The Committee believes that it is appropriate to allow the donee to receive the depreciable basis of the donor. The Committee is merely continuing the policy regarding donation of assets as contained in regulations.

The Committee intends that the Secretary provide exceptions to the revaluation of asset provision for non-profit organizations who

obtain ownership of a State owned general acute care hospital for nominal consideration. The exception would provide that the basis for which capital-related costs are determined to the non-profit organizations would be the prior owner's historical cost (net of depreciation).

Effective date.—The provision would be effective as if it had been originally included in the DEFRA.

12. Report on impact of outlier and transfer policy on rural hospitals (sec. 112 of the bill)

Present law.—Present law requires that additional payments be made under the prospective payment system for hospitals when there is either an unusually long length of stay or the stay is excessively costly (both as defined by the Secretary). Regulations of the Secretary prescribe rules for PPS payment in cases where patients are transferred between hospitals.

Explanation of provision.—The Secretary of Health and Human Services would be required to review the impact of the outlier and transfer policies under the PPS system especially as they relate to rural hospitals with less than 100 beds.

The Secretary would be required to report to Congress on the findings of the review not later than March 1, 1986, and should include in this report recommendations on changes in these policies to the extent that they adversely affect rural hospitals.

Effective date.—The provision would be effective upon enactment.

13. Information on impact of PPS payments on hospitals (sec. 113 of the bill)

Present law.—Under the Congressional Budget Act of 1974, the Congressional Budget Office (CBO) is entitled to the most recently available cost reports submitted by medicare participating hospitals to the Department of Health and Human Services. There is no requirement that the House of Representative's Committee on Ways and Means or the Senate's Committee on Finance receive cost report information on hospitals that participate in the medicare program.

Explanation of provision.—The bill would require the Secretary of Health and Human Services to make available to the Prospective Payment Assessment Commission (ProPAC), the Congressional Budget Office, and to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the most current information on the payments being made under the prospective payment system to individual hospitals.

The hospital specific information would be treated as confidential and would not be subject to further disclosure in a manner that would permit the identification of individual hospitals.

There has been a great deal of concern that the Department of Health and Human Services has not submitted hospital cost report and medicare payment information from hospitals participating in the medicare program in the most timely fashion. As a result, CBO has not had enough time to properly analyze proposals under consideration by this Committee. Further, the Committee has been frustrated in its attempts to fully understand the impact of the

new prospective payment system on hospitals in different areas of the country, or on specific categories of hospitals that participate in medicare, because it has lacked data available to the Department of Health and Human Services. In order to more effectively legislate in this area the Committee believes that it needs more comprehensive data.

Effective date.—The provision would be effective upon enactment.

14. Extension and payment for hospice care (sec. 121 of the bill)

Present law.—Under current law, individuals who are entitled to medicare part A benefits and who are certified to be terminally ill may elect to receive part A reimbursement for hospice care services, in lieu of certain other services. Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized this hospice benefit, mandated reports to the Congress by the Secretary of Health and Human Services on September 30, 1983 (regarding the Department's hospice demonstration project) and January 1, 1986 (evaluating the hospice benefit). Current authority for the medicare hospice benefit is scheduled to sunset on October 1, 1986.

In implementing the TEFRA hospice benefit, the Department of Health and Human Services established a prospective payment system and set daily rates for each of four levels of hospice care. Public Law 98-617 increased the routine home care payment rate by approximately $7.00 per day for the fiscal year beginning October 1, 1984, and required the Secretary of HHS to review and adjust the hospice rates annually, beginning October 1, 1985.

The report on the hospice demonstration project, which was to have been submitted by September 30, 1983, has not yet been received by the Congress, and it is clear that no comprehensive evaluation of the hospice benefit will be available for review by the Congress prior to October 1, 1986. In addition, it appears that meaningful cost data will not be available to the Secretary in order for the rates to be updated by October 1, 1985.

Explanation of provision.—The bill would repeal the sunset provision of present law. Beginning October 1, 1985, each of the daily payment rates for hospice care would be increased by $10.00, an amount which is slightly less than the Congressional Budget Office estimate of the savings per day attributable to a medicare hospice election. The Secretary would be given one additional year, until October 1, 1986, to review and adjust the hospice rates and to report to the Congress on the adequacy of the rates in insuring participation in medicare by an adequate number of hospice programs.

Effective date.—The repeal of the sunset provision would be effective on enactment of the bill and the rate increases would be effective for hospice care furnished on or after October 1, 1985.

15. Limiting the penalty for late enrollment in part A (sec. 122 of the bill)

Present law.—Under present law, part A coverage under medicare is available on a voluntary basis to individuals 65 or over who are not otherwise entitled to coverage. These individuals may obtain medicare part A coverage by paying a monthly premium.

Anyone purchasing part A coverage after the third month after the month in which he becomes eligible is charged a late penalty of 10% of the standard premium for each 12 months he is late in enrolling; that is, for each 12 months during which he could have been, but was not enrolled. This penalty is paid each and every month of coverage for the rest of the beneficiary's life.

Explanation of provision.—The Committee believes that these premium penalty provisions are too severe. They can involve large percentage increases in premium amounts which, by themselves, are quite large. The bill would limit the part A premium penalty to 10% no matter how late an individual enrolled, and the period during which the penalty is paid would be limited to twice the number of years enrollment was delayed. At the end of this period, the premium would revert to the standard monthly premium in effect at that time. For example, if the individual enrolled one year late, the penalty would be 10%, paid for two years; for late enrollment for two years, the penalty would be 10% a year for four years, and so on, after which it would revert to the standard premium amount.

The bill would also apply to medicare beneficiaries currently paying a part A premium penalty. Months before, during or after January 1986, in which such an individual was required to pay a premium penalty, would be taken into account in determining the month in which the premium would no longer be subject to a penalty increase.

Effective date.—The provision would apply to premiums payable for January 1986, and thereafter.

16. Medicare coverage of, and application of hospital insurance tax to, newly-hired state and local government employees (sec. 123 of the bill)

Present law.—Most State and local government employment is covered under social security (for social security monthly benefits and medicare) as a result of voluntary agreements for such coverage entered into by the States. This coverage is not mandatory, but governmental units whose employees have such coverage are not permitted to withdraw their employees from coverage. Some 25–30 percent of State and local employment is not covered under social security.

Explanation of provision.—Individuals who have worked in State and local government employment that is excluded from social security coverage are often able to acquire insured status and thus to qualify for social security and medicare benefits nonetheless. They qualify as a result of work performed in other employment covered under the program or through the entitlement of a spouse. It is estimated that perhaps 95 percent of all State and local employees eventually qualify for benefits. By and large, individuals who qualify after having worked in excluded State and local government employment have contributed significantly less in social security FICA taxes than others who become entitled to benefits. They therefore represent a financial drain on the system, and especially on the medicare hospital insurance program.

Unlike monthly social secuirty benefits, where minimal covered earnings and tax contributions result in minimal benefit amounts

entitlement to medicare is entitlement for the full range of benefits. The benefits are the same regardless of whether the insured worker has made significant tax contributions over his working lifetime or whether he has qualified with the minimun number of quarters of coverage. The Committee believes that the time has come to begin the correction of this problem as it relates to the medicare program.

Accordingly, the Committee bill would extend medicare coverge on a mandatory basis for newly-hired employees of State and local government entities. The employers and their employees would become liable for the hospital insurance portion of the FICA tax and the employees would earn credit toward medicare eligibility based on their covered earnings. Mandatory coverage would be extended only for medicare and only for employment not otherwise covered under voluntary State coverage agreements.

The Committee believes that the future medicare entitlement of State and local government employees will in many cases have the effect of reducing the costs of existing health benefit programs for employees and retirees of the affected governmental entities. Nonetheless, the Committee is aware of concerns among State and local governments about the financial burden that mandatory medicare coverage for all their employees might represent. Accordingly, the extension of mandatory coverage would be applicable to employees hired on or after January 1, 1985.

The Committee anticipates that the Secretary of the Treasury will issue regulations relating to the collection of the new mandatory FICA taxes with respect to State and local government employment and relating to the technical rules under which it will be determined whether an individual employee is newly hired and thus covered, or has in fact not been separated from his previous excluded employment and thus remains excluded from mandatory coverage.

The Committee recognizes that in many cases where few employees of a State and its local jurisdictions have previously participated in social security, the pressure will be great to seek to avoid coverage under this provision. The provision exempts from coverage only employees of State and local governments, legitimately employed by those governments prior to January 1, 1986. The Committee expects that the Internal Revenue Service will carefully scrutinize the circumstances of those claiming to be exempt whose employment connection with the State or local entity prior to January 1, 1986, appears tenuous or questionable.

The Committee also recognizes that defining entities as separate employers for purposes of determining whether an employee has been hired by a State or local entity after 1985, may pose complex issues for the Internal Revenue Service. It should be generally true that employees who move between different jobs in different integral units of a State government, such as different departments within the State government, would be considered continuously employed by the State, while employees who move from State government employment to a job with a local township, county or municipality, or vice versa, would be considered to be newly hired. The Committee expects that cases in which the distinctions are

more difficult to make will be judged according to the independence of the second employing unit from the first, as an employer.

Effective date.—The provision is effective with respect to service performed after December 31, 1985 by emplyees hired by a State or local government after that date.

17. Responsibilities of medicare hospitals in emergency cases (sec. 124 of the bill)

Present law.—Under current law, hospitals that participate in medicare have to meet defined conditions of participation and enter into participation agreements. There are no specific requirements relating to the appropriate treatment of emergency patients, including non-medicare patients.

Explanation of provision.—The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.

There is some belief that this situation has worsened since the the prospective payment system for hospitals became effective. The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.

All participating hospitals with emergency departments would be required to provide an appropriate medical screening examination for any individual who requests it (or has a request made on his behalf) to determine whether an emergency medical condition exists or if the patient is in active labor.

All participating hospitals must, when a patient is found to have an emergency condition or to be active labor (1) provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor, unless such treatment is refused or (2) provide an appropriate transfer to another medical facility in accordance with a defined standard.

A hospital may not transfer or discharge a patient who has not been stablized or is in active labor unless: (1) there is a written determination by a physician based on the information available at the time and using reasonable standards that the benefits to be obtained from appropriate medical treatment at another facility outweigh the risks of transfer and (2) that the receiving facility has agreed to accept the patient, has space and qualified personnel available for his treatment and is provided with medical examination and treatment records from the transferring hospital. The transfer must be made by proper personnel using equipment that meets health and safety standards.

A hospital that fails to meet these requirements may have its medicare participation agreement terminated or be subjected to civil money penalties of not more than $25,000 for a knowing viola-

tion of this provision. Any person or entity adversely and directly affected by a participating hospital's violation of these requirements may bring an action, in an appropriate state or Federal district court, for damages to the person arising from the violation and for other relief as may be appropriate to remedy the violation or deter subsequent violations.

A physician who has professional responsibilitie for the provision of a screening examination or for the treatment of a patient, who knowingly fails to meet his responsibilities, as discussed below, will be subject to criminal penalties including a fine of not more than $100,000 or up to a year in prison or both, or, if the patient dies as a direct result of this failure, a fine or not more than $250,000 and a prison term of not more than five years, or both.

Criminal sanctions may be invoked if:

(1) the physician knowingly fails to provide for a screening examination in the emergency department if the failure represents a gross deviation from the prevailing local standards of medical practice or if the screening examination is conducted in a manner that is so inappropriate so as to represent a gross deviation from the prevailing local standards of medical practice, or

(2) the physican responsible for treatment knows or has reason to know that a patient has an emergency medical condition or is in active labor and knowingly—

(a) fails to provide for treatment to stabilize the patient if the failure represents a gross deviation from prevailing local medical practice or provides for treatment in a manner that is so inappropriate as to represent a gross deviation from prevailing standards of local medical practice; or

(b) orders the patient who has not been stabilized to be transferred other than to a medical facility, or to a medical facility that does not have space available and has not agreed to accept the patient.

Effective date.—The provision would be effective October 1, 1985.

B. Changes Relating to Parts A and B of the Medicare Program

1. Extension of working aged provisions to individuals over 69 (sec. 131 of the bill)

Present law.—The Age Discrimination in Employment Act (ADEA) requires employers of 20 or more people to offer employers and their spouses age 65 through 69 the same health insurance coverage they offer to their younger employees and under the same conditions.

If the older employee chooses the employer's plan, medicare becomes the secondary payor if the employer plan does not pay full benefits.

If the older employee chooses not to participate in the employer's plan, medicare will be the primary payor. The employer is prohibited from offering a health plan designed to supplement medicare, (i.e. fill in medicare's deductibile and coinsurance).

Currently, ADEA applies only to persons between the ages of 40 and 70.

Explanation of provision.—(a) The bill would extend the health insurance requirement of ADEA to persons over the age of 69, thereby removing the upper age limit, and makes corresponding changes in medicare law.

(b) ADEA would be amended to provide that the group health insurance requirement be exempted from the age limits.

(c) The bill would make other conforming amendments regarding special enrollment periods and the effective date of enrollment.

Effective date.—The effective date of paragraph (a) would apply to items or services furnished on or after January 1, 1986.

The effective date of paragraph (b) would be January 1, 1986.

The effective date of paragraph (c) would be January 1, 1986, with certain exceptions.

2. Provisions relating from health maintenance organizations and competitive medical plans (sec. 132 of the bill)

(a) Financial responsibility for patients hospitalized on the effective date of an enrollment or disenrollment.

Present law.—Under current law it is unclear who is responsible for payment when a medicare beneficiary is an inpatient of a hospital under the prospective payment system on the effective date of his/her TEFRA HMO/CMP enrollment. A similar problem exists for disenrollment. A TEFRA HMO/CMP is a health maintenance organization or competitive medical plan with a risk contract under Section 1876 of the Social Security Act, authorized under the Tax Equity and Fiscal Responsibility Act of 1982.

Explanation of provision.—Enrollment—a TEFRA HMO/CMP is not financially responsible for reimbursing covered inpatient stays in a PPS hospital for inpatient stays beginning before the effective date of the beneficiary's enrollment in the TEFRA HMO/CMP. Medicare will reimburse for the inpatient stay, if otherwise covered, as if the beneficiary were not enrolled in a TEFRA HMO/CMP. The TEFRA HMO/CMP will be responsible for any other services covered under medicare (i.e., all services except the inpatient stay, such as physician services provided to the patient during the inpatient stay) and any additional or supplemental services which would otherwise be due an enrollee, effective with the date of his/her enrollment in the TEFRA HMO/CMP. Medicare will make its normal monthly capitation payment to the TEFRA HMO/CMP beginning with the effective date of the enrollment, in addition to reimbursing for the inpatient stay. The enrollee is responsible for premium or other payments due to the TEFRA HMO/CMP effective with the effective date of enrollment.

Disenrollment—if the enrollee is an inpatient in a PPS hospital on the effective date of his/her disenrollment from the TEFRA HMO/CMP, the TEFRA HMO/CMP will be responsible for reimbursing for the full inpatient stay. Medicare will not make a monthly capitation payment nor will it pay for the inpatient stay under the regular medicare program after the effective date of enrollment. The TEFRA HMO/CMP is not responsible for any other covered medicare services, or any additional or supplemental services to the enrollee, beginning on the effective date of disenrollment. This provision would apply only if the enrollee is an inpatient of a PPS hospital provided for or arranged by the TEFRA

HMO/CMP, or if the services were emergency or urgently needed services. The enrollee is not responsible for any premium or other payments to the TEFRA HMO/CMP effective with the month of disenrollment.

Effective date.—The provision is effective for enrollments and disenrollments effective on or after October 1, 1985.

(b) Disenrollment procedures.

Presemt law.—Present law specifies the effective date disenrollment from a TEFRA HMO/CMP to be the first calendar month following a full calendar month after the request is made for termination.

Explanation of provisions.—Disenrollments would be effective with the first day of the first month following the month in which the disenrollment request was made. The provision would require that the beneficiary receive a copy of the disenrollment form and that materials be provided to the beneficiary explaining how long he/she must continue to use the HMO/CMP facilities in order to have the services covered.

The Committee is concerned that medicare enrollees should be able to disenroll form TEFRA HMO/CMP without experiencing long delays. The current law provisions could result in a delay of up to 60 days between the time the beneficiary rquests disenrollment and the effective date of disenrollment. As a result of new computer systems the Health Care Financing Administration Can now facilitate faster disenrollment. This provision would ensure that a medicare enrollee would never have to wait more than 30 days before the disenrollment request was effective.

In addition, the Committee is concerned that medicare beneficiaries may believe that filing a request to disenroll means they can immediately use the regular fee-for-service medicare program. This is not the case and the Committee is requiring that information be provided to beneficiaries clearly delineating when they may begin to use the regular medicare benefit.

Effective date.—The provision is effective for requests for termination of enrollement submitted on or after October 1, 1985.

(c) Review of marketing material.

Present law.—There are no present law provisions relating to marketing materials.

Explanation of provision.—The bill would require all TEFRA HMO/CMPs to submit all brochures, application forms, and promotional and informal material to the Health Care Financing Administration (HCFA) for approval, at least 45 days before issuance. HCFA would be required to review all these materials. If the HMO did not hear from the HCFA within the 45-day period, the organization could assume approval.

The Committee is concerned that there have been problems with the HMO demonstratins and with some of the ongoing TEFRA HMO/CMPs regarding their marketing materials. Some marketing materials have been misleading, or have not provided complete information to the medicare beneficiaries.

In the proposed regulations implementing the TEFRA HMO/CMP legislation the Secretary would have required review of marketing materials by HCFA for accuracy and completeness. These provisions were dropped when the final regualtions were published.

The Committee is concerned that in several instances marketing material supplied to medicare beneficiaries has been misleading, inaccurate and, in some cases, has provided "incentives" to join, which are prohibited by statute. Considering that the TEFRA HMO/CMP benefit is a new benefit and a substantial departure from the traditional method of obtaining services under the medicare program, the Committee feels that a stringent review of marketing materials should be undertaken to ensure accurate description of both the benefit package available to TEFRA HMO/CMP beneficiaries and the limitations, if any, on the providers whose services they can use as enrollees. The Committee wishes to stress that the marketing material should explain the issue of the "lock-in" in full to beneificiaries prior to their signing up with the HMO/CMP, so that they are well-informed of the limitations on the providers from whom they may seek services.

The Committee understands that his will create an added burden on the central office of HCFA, but believes that this effort is necessary, at least for the early years of implementation of this benefit, in order to protect the interests of the medicare beneficiaries for whom this program designed.

Effective date.—The provision would apply to material for distribution on or after November 15, 1985. This provision would not apply to material which has been distributed prior to November 15, 1985.

(d) Prompt publication of the AAPCC.

Present law.—In order to establish the payment amounts to TEFRA HMO/CMPs the Secretary has developed a measure, called the Average Adjusted Per Capita Cost (AAPCC). There are no current law requirements relating to the specific date of publication of the AAPCC.

Explanation of provision.—The provision would require the Secretary to publish the AAPCC no later than September 7 of each year. The Committee believes that the Secretary has been slow in publishing the AAPCC. The Committee believes that both HMO/CMPs and HCFA should have as much time as possible to develop their adjusted community rate and to determine their benefit packages. In order to facilitate this, the Committee is requiring that the AAPCC be published six days after the final promulgation of the prospective payment regulations, required by law to be published September 1.

Effective date.—The provision would apply to determinations of per capita rates of payment for 1987 and subsequent years.

3. Evaluation of preadmission and pre-procedure certification programs (sec. 133 of the bill)

Present law.—Peer review organizations (PROs), with general responsibility to review quality and utilization for inpatient hospital services, have been directed specifically to reduce the rate of inappropriate admissions. All PROs do preadmission screening on some elective surgery. Four PROs are currently responsible for 100% preadmission review of non-emergency surgery.

PROs currently do not have authority to review outpatient care.

Explanation of provision.—The Secretary of HHS would be required to evaluate the efficacy of PRO programs with 100% pread-

mission elective surgery review compared with programs that include less comprehensive review.

The Secretary would be required to evaluate the feasibility of extending to PRO pre-procedure certification activities to outpatient and ambulatory settings. The Secretary would also be required to consider whether other organizations, including medicare carriers could more effectively conduct such pre-procedure screening.

Effective date.—A report to Congress would be due by December 31, 1986.

4. Prohibition of administrative merger of renal disease networks with other organizations (sec. 134 of the bill)

Present law.—The Secretary is required by statute to establish networks to assure the effective and efficient administration of the end stage renal disease (ESRD) program under medicare. The network organizations are responsible for performing functions which include: (1) encouraging the use of treatment settings most compatible with the successful rehabilitation of the patient; (2) developing criteria and standards relating to the quality and appropriateness of patient care; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation; and (3) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities.

Explanation of provision.—The bill would prohibit the Secretary from dismantling ESRD networks, or from consolidating their organizations and functions with Peer Review Organizations or any other entity without express statutory authorization.

Effective date.—The provision would be effective on enactment.

5. Extension of certain medicare HMO demonstration projects (sec. 135 of the bill)

Present law.—Present law permits waiver of certain medicare requirements when the Health Care Financing Administration enters demonstrations under its general demonstrating authority.

Explanation of provisions.—The Secretary would be required to extend for three additional years, the three municipal health services demonstration projects (Milwaukee, San Jose and Cincinnati) currently authorized under medicare demonstration authority. These demonstrations were authorized under authority provided in the Social Security Amendments of 1967 and 1972.

These demonstrations are explicitly designed to increase the access to medical care of underserved low-income medicare and medicaid beneficiaries. As currently structured these HMOs would fail to meet the enrollment mix criteria of the TEFRA HMO/CMP provisions. The Committee has decided to extend these demonstrations for three more years in order to provide them with the opportunity to meet the enrollment mix and other criteria required in order to qualify as TEFRA HMO/CMPs at the end of this three-year extension period. The Committee understands that these projects are moving toward a capitated basis of payment and the Committee action does not preclude the Secretary from moving toward a capitated payment method. The Committee expects these HMOs to begin enrolling private enrollees at the earliest opportu-

nity. The Committee directs the Secretary to continue to monitor these projects to assure that there is no deterioration in the quality of care provided by the projects.

Effective date.—Effective upon the date of enactment.

6. Technical Corrections (sec. 136 of the bill)

Present law.—Current medicare law contains a number of technical errors.

Explanation of provision.—(a) The bill would correct problems with the medicare special enrollment period and the premium penalty forgiveness for the working aged. The bill would correct an anomaly under which certain individuals who are working and covered by an employer group health plan receive only one special enrollment period and others receive more than one.

(b) In addition, it would make it clear that an individual would be eligible for forgiveness of the medicare premium penalty for any period during which he or she was over 65 and covered by an employer group health plan.

The provision requiring a person to meet the eligibility requirements of part A and to have filed for part A would be repealed.

(c) The bill would make certain corrections in spelling, language and indentation.

Effective date.—The changes made by paragraph (a) would apply to the first month that begins more than 90 days after the date of enactment with certain exceptions.

The changes made by paragraph (b) would apply to months beginning January 1983 for premiums for months beginning with the first month that begins more than 30 days after the date of enactment.

The changes made by paragraph (c) would generally be effective as through they had been included in the public laws that they correct.

C. Changes Relating Primarily to Part B of the Medicare Program

1. Extension of physician fee freeze for nonparticipating physicians and improvements in the participating physician program (sec. 141 of the bill)

Present law.—Medicare pays for physician services on the basis of medicare-determined "reasonable charges". Reasonable charges are the lesser of: (1) a physician's bill charge; (2) the charge customarily made by an individual physician; or (3) the prevailing charge limit, derived from a statisitical analysis of charges made by all physicians for services in a geographic area. The customary and prevailing charge screens are generally updated annually, on October 1. Increases in the prevailing charge levels are limited by an economic index that reflects general inflation and changes in physicians' office practice costs.

Under the Deficit Reduction Act of 1984 (P.L. 98-369) the medicare customary and prevailing charges for all physicians' services provided during the 15-month period beginning July 1, 1984 are frozen at the levels that applied for the 12-month period ending June 30, 1984. The actual charges of nonparticipating physicians

are also frozen during the 15-month period, at the levels they charged during April-June 1984.

The Deficit Reduction Act also instituted a medicare participating physician and supplier program. Participating physicians and suppliers voluntarily agree to accept assignment on all medicare claims for the 12-month period beginning on October 1 of a year. Nonparticipating physicians and suppliers can decide on a claim-by-claim basis whether or not to accept assignment.

The carriers responsible for paying medicare claims are required to monitor nonparticipating physicians' actual charges during the 15-month freeze. Physicians who knowingly and willfully bill beneficiaries in excess of what they charged during April-June 1984 can be subject to civil monetary penalties and/or exclusion from participation in medicare.

Explanation of provision.—Beneficiaries who receive services from participating physicians and suppliers know in advance of receiving services that all the services provided to them will be taken on an assigned basis, and that they will not incur out-of-pocket costs, outside of deductible and coinsurance amounts mandated by statute.

In order to encourage participation, the bill would establish direct financial incentives to physicians to participate. On October 1, 1985, any physician who enters into a participation agreement effective for the year beginning October 1, 1985, or who extends an existing agreement, would receive an update in customary and prevailing charges. The same prevailing charge screens would apply to all participating physicians, regardless of their participation status in the previous year. This is intended to provide an incentive for physicians to participate, and reflects the priority the Committee attaches to increasing participation rates.

With regard to customary charge updates, physicians who are participating for a second year may realize some advantage over physicians who are signing agreements for the first time. The updated customary charges of physicians who continue to participate would reflect their (unfrozen) actual charges made from April 1984 through March 1985. The updated customary charges of new participants would be based on their actual charges from the same period, but these physicians' actual charges were frozen at April-June 1984 levels.

The prevailing charge limits on which reasonable charge determinations for participating physicians would be based would reflect the updated customary charges of all physicians. Customary charges of nonparticipating physicians would be calculated (based on actual charges made from April 1984 through March 1985, although they were frozen at April-June 1984 levels) but these customary charges would be used solely for the purpose of computing updated prevailing charges for participating physicians; they would not be used to determine payment for nonparticipating physicians.

For any physician who is not covered by a participation agreement effective for the year beginning October 1, 1985, the current 15-month freeze on customary and prevailing charges would be extended for 12 months, beginning October 1, 1985.

The current freeze on the actual charges of nonparticipating physicians would also be extended for 12 months. This freeze at April-

June 1984 levels would apply to all physicians who are not participating physicians for the year beginning October 1, 1985, and is intended to protect beneficiaries from increased financial liability for the period during which medicare payments to nonparticipating physicians are frozen. For a physician who are participating in FY 1985 but drops out of the participation program in FY 1986 the freeze on medicare payments would apply, and, in addition, the newly nonparticipating physician would have his actual charges rolled back to the level charged in the period April/June 1984. The monitoring of nonparticipating physicians' actual charges would be continued through FY 1986.

On October 1, 1986, any physician who is covered by a participation agreement effective for the year beginning October 1, 1986 would receive customary and prevailing charge updates. Nonparticipating physicians for the year beginning October 1, 1986 would receive customary and prevailing charge updates. However, they would be subject to the prevailing charge limits that applied to participating physicians during the year beginning October 1, 1985 (the preceding fee screen year).

The continued application of this differential in prevailing charge screens would apply in future years. Thus a permanent differential would be established between the prevailing charges to which participating and nonparticipating physicians are subject to the prevailing charges applied to participating physicians in the previous year.

In response to complaints by participating physicians regarding billing and claims processing problems they encountered during the first year of the participating program, the bill would provide for the development of professional relations staff at the carriers dedicated exclusively to addressing the billing and other problems of participating physicians and suppliers.

The Committee intends that the Secretary devote sufficient funds to the carriers for maintenance of their toll-free telephone lines so that they are useful to beneficiaries seeking information about participating physicians and suppliers. Sufficient resources should also be devoted to ensure that participating physicians and suppliers enjoy the benefit of the carriers' direct lines for the electronic receipt of claims.

The bill eliminates the statutory requirement in the Deficit Reduction Act for publication of the Physician Assignment Rate List (PARL), which lists the name, address, specialty and previous year's assignment rate for all physicians and suppliers, irrespective of their participation status. The PARL is said to be confusing to beneficiaries and little used.

The Committee intends that the directories of participating physicians and suppliers be organized so as to be meaningful and useful to beneficiaries. For example, if, in especially large metropolitan areas, local medical markets can be identified, these should serve as the basis for organizing the directories.

The bill would require that the appropriate area directories be sent to all participating physicians in an area to facilitate and encourage the development of referral networks among participating physicians and suppliers. The Committee also expects that copies of the appropriate area directories of participating physicians and

suppliers be sent to the local and national offices of each Member of Congress to facilitate responses to beneficiaries' inquiries for information on the participating physicians and suppliers in their area.

The bill includes a provision which would require that, for all unassigned claims, the Explanation of Medicare Benefits (EOMB), provided to all medicare beneficiaries include a message reminding beneficiaries of the participating physician and supplier program, and providing them with the toll-free number for information in their area. The message would also remind beneficiaries of the limitation on the charges participating physicians and suppliers may impose; that is, that they cannot charge beneficiaries extra-billing amounts. The bill specifies that this provision be implemented by April 1, 1986. This gives the Secretary ample time to pilot-test messages, if necessary, to insure that they convey information to beneficiaries in a meaningful and appropriate fashion.

The provision in the Deficit Reduction Act for the transfer in fiscal year 1985 of $15 million from the Federal Supplementary Medical Insurance trust fund to the carriers would be extended to apply to fiscal year 1986 (in the same amount), for the continued administration of the physician fee freeze and participating physician and supplier program.

Effective date.—The fee freeze and participating physicians provisions would apply to services furnished on or after October 1, 1985.

2. Expansion of membership and duties of the Prospective Payment Assessment Commission to include review of payments for physicians' services (sec. 142 of the bill)

Present law.—There currently exists no advisory body whose purpose it is to make recommendations regarding medicare physician payment.

Explanation of provision.—The Director of the Congressional Office of Technology Assessment would expand the membership of the Prospective Payment Assessment Commission to total 23 by appointing, not later than January 1, 1986, eight additional members to the Commission.

The Committee intends that two of the eight new appointments be reserved for representatives of rural hospitals and the nursing profession. The Committee also intends that rural physicians be represented by one of the six remaining new members.

The Chairman of the Commission would provide for two subcommittees of the Commission, one whose functions and responsibilities relate primarily to hospital payment issues and the other whose functions and responsibilities relate primarily to physician payment issues. The Committee anticipate that the Commission would act principally through these subcommittees; that is, the subcommittee with jurisdiction over a particular issue would be assigned to study it, and recommendations would emanate from that subcommittee. The Committee expects that the Commission would act as a whole only on occasions when the subcommittees' jurisdiction is overlapping.

The Chairman would have the discretion to assign members of the Commission to serve on either or both subcommittees, but

would initially assign to serve on the hospital payment subcommittee of the Commission all of the current members of the commission and the two newly appointed rural hospital and nurse representatives. The Chairman would initially assign to the physician payment subcommittee of the Commission the six remaining new members. The Commission would also employ as many as ten additional staff members (beyond the existing limit of 25 plus an executive director), and would have the discretion to assign staff to either or both subcommittees as appropriate, in light of the workload and particular skill requirement of the respective subcommittees.

The mission and dutis of the physician payment subcommittee would be to make recommendations to the Congress by February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services, and changes in the methodology for determining and making payment for medicare physicians' services and other items and services under part B.

In making its recommendations, the physician payment subcommittee would consider and develop options concerning reduction of existing specialty and geographic differentials in the payment amounts for physicians' services under part B, and would review the input costs associated with the provision of different physicians' services. The subcommittee would identify reasonable charges that seem out-of-line.

The subcommittee would assess the likely impact of adjustments in payment rates on utilization, on physician participation in the participation program, and on beneficiary access to physicians' services. The subcommittee would also make recommendations on ways to increase participation and assignment rates.

The physician payment subcommittee would identify procedures for which payments for assistants-at-surgery should be eliminated; and procedures for which second opinions should be required.

The bill would require the subcommittee to develop recommendations on the advisability and feasibility of making changes in the medicare physician payment mechanism, based on the HHS study of physician DRGs and the OTA study of fee schedules.

The subcommittee would also advise the Secretary on the development of a relative value scale (RVS). The Committee expects that the physician payment subcommittee in making its recommendations, and the Secretary in developing an RVS, will consider such factors as the input costs of furnishing particular physicians' services, and existing charge levels. Analysis of the input costs of all physicians' services would not be required, but the committee expects that services and items which are high volume among the medicare population, or which account for a long share of medicare physician spending, or for which the charges seem "out-of-line" would be examined. Services that can appropriately be "bundled," and for which medicare payment could be made on the basis of a global or comprehensive fee would also be idnetified and considered in developing the RVS.

In developing the RVS, the Secretary would be directed to consider the OTA study of fee schedules and the subcommittee's recommendations. The Secretary would be required to report to Con-

gress on the development of the RVS not later than April 1, 1987 for implementation October 1, 1987. The committee expects that the report would include an analysis of the likely impact of the RVS on participation and assignment, access to care and utilization.

Effective date.—The provision would be effective October 1, 1985.

3. Part B premium (sec. 143 of the bill)

Present law.—The Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for people enrolled in the Supplementary Medical Insurance (part B) portion of medicare. A temporary provision of law requires that for 1986 and 1987 the premium amount be calculated so as to produce premium income equal to 25 percent of program costs for enrollees age 65 and over.

Beginning in 1988, the premium calculation would revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged; or (2) the current premium amount increased by the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the Social Security program.

Explanation of provision.—The bill would extend for one additional year the existing temporary provision whereby the portion of part B costs financed by enrollee premiums equals 25 percent of program costs. If there is Social Security cost-of-living adjustment, the monthly premium would not be increased for that year.

Effective date.—The provision would be effective on enactment.

4. Determinations of inherent reasonableness of charges and charges and customary charges for certain former hospital-compensated physicians (sec. 144 of the bill)

Present law.—(a) Inherent reasonableness—Payment for items and services under part B is generally made on the basis of reasonable charges. The reasonable charge is defined as the lowest of the actual charge, the customary charge and the prevailing charge for a given item or service. An economic index limits increases in prevailing charges for physicians' services. The law provides for some flexibility in the determination of reasonable charges, and regulations specify criteria that may be used in making these determinations. The regulations at 42 CFR 405.502(a)(7) allow the use of "other factors that may be found necessary and appropriate with respect to a specific item or service . . . in judging whether the charge is inherently reasonable."

(b) Hospital-compensated physicians—With the elimination of combined-billing arrangements, effective October 1, 1983, carriers established compensation-related customary charges (CRCCs) for certain hospital-based physicians. The CRCC provision was intended to be transitional; hospital-based physicians would have received customary charge updates on July 1, 1984 based on their actual charges had it not been for the freeze on medicare customary and prevailing charges for physicians' services instituted by the Deficit Reduction Act.

Explanation of provision.—(a) Inherent reasonableness—The provision would require the Secretary to publish regulations which (1) specify the factors to be used in determining the cases (of particular items and services) for which the applications of the reasonable charge methodology results in reasonable charges that, by reason of their grossly excessive or grossly deficient amounts, are not inherently reasonable, and (2) specify, in such cases, the factors that will be considered in establishing reasonable charges that are realistic and equitable. The requirement for promulgation of such regulations is intended to prevent arbitrary application of inherent reasonableness and to expose to public comment the process and criteria to be used.

In indentifying the kinds of cases in which to apply inherent reasonableness criteria, the Secretary should consider situations such as those in which charges (1) are substantially in excess of acquisition or production costs; (2) reflect a market dominated by one or few providers or suppliers; (3) do not reflect changes in technology; (4) are substantially higher to medicare patients than to others; or (5) reflect unrealistically low payment amounts, such as those that resulted from the application of the CRCC methodology for hospital-based physicians.

In establishing a reasonable charge that is realistic and equitable, the Secretary could specify that such factors as charges in other localities and manufacturers' wholesale price lists or suggested retail prices be considered.

This provision is to provide for adjustments in cases in which the charges determined by the reasonable charge methodology are not inherently reasonable. The Committee does not intend that this provision be used as a means to alter the basic methodology for determining reasonable charges, or to challenge such practices as recognizing speciality and geographic differentials in payment.

(b) Hospital-compensated physicians—Hospital-based physicians (HBPs) who, between October 31, 1982 and January 31, 1985, were in (and within the same time period terminated) arrangements by which they were compensated by a hospital for part B services furnished to its patients, would receive customary charges based on their actual charges.

On October 1, 1985, participating physicians who are covered by this provision would have their customary charges updated based on actual charges made during the 12-month period ending March 31, 1985. This is the same base period used to update the customary charges of other participating physicians. Nonparticipating physicians covered by this provision would have their customary charges updated on October 1, 1985 based on actual charges serving the same base period, but their customey charges would be deflated to approxiate levels based on 1982 actual charges, on which other nonparticipating physicians' customary charges would be are based under the bill.

The bill specifies that the customary charges of the nonparticipating physicians would be deflated by multiplying them by .83. This factor was determined by taking the ratio of the physicians' services component of the CPI (all urban consumers, seasonally-adjusted) for September 1984 and June 1982, the midpoints of the

base periods of the October 1, 1985 and July 1, 1984 fee screen updates, respectively.

On October 1, 1986, participating and nonparticipating physicians covered by this provision would be treated the same as all other participating and nonparticipating physicians.

Effective date.—The provisions relating to inherent reasonableness are effective upon enactment and the provisions with respect to hospital-compensated physicians would be applicable with respect to services furnished on or after October 1, 1985.

5. Occupational therapy services (sec. 145 of the bill)

Present law.—Occupational therapy is a medically prescribed treatment concerned with improving or restoring functions that have been impaired by illness or injury or, when functions have been permanently lost or reduced by illness or injury, with improving the individual's ability to perform those tasks required for independent functioning.

Medically necessary occupational therapy services are covered under part A of medicare when provided as a part of covered inpatient or post-hospital extended care services in a skilled nursing facility, or as part of home health services or hospice care.

Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency or when incident to a physician's service.

Explanation of provision.—The bill would extend reimbursement under part B of medicare for occupational services. Occupational therapy would be covered when provided in a skilled nursing facility (when part A coverage is exhausted), in a clinic, or a rehabilitation agency. Payment would be make on a reasonable cost basis.

In addition, occupational therapy services furnished in a therapist's office or a beneficiary's home would be covered. The independently practicing therapist would be required to meet licensing and other standards prescribed by the Secretary. No more than $500 in incurred expenses would be eligible for coverage in a calendar year per beneficiary. Payment would be based on 80% of reasonable charges.

Generally speaking, the bill would make medicare coverage of occupational therapy services comparable to the existing coverage of physical therapy services.

The Committee believes that the value of occupational therapy services to beneficiaries merits a modest expansion of the program. Further, the Committee finds that such services have the potential to reduce and avoid the need for institutional care while enabling the beneficiary to function more independently.

Effective date.—The bill would be effective for items or services furnished on or after October 1, 1985.

6. Payment for durable medical equipment (sec. 146 of the bill)

Present law.—Durable medical equipment (DME) is a covered part B benefit reimbursable on the basis of reasonable charges. In the past, medicare payment for DME was made for both rented and purchased items, depending on the beneficiary's decision to either rent or purchase. As a result, the majority of DME was rented, even when purchase would have been more economical.

Beginning February 1, 1985, the Secretary implemented three methods for reimbursing DME under medicare: lease-purchase, lump sum purchase or rental charges. Equipment costing less than $120 is considered inexpensive equipment and payment is made only on the basis of purchase. For equipment costing more than $120, the carrier must determine which method is cost-effective based on the beneficiary's expected need for the equipment (as indicated on the physician's prescription) and reimburse accordingly. Used equipment that is purchased and that meets certain standards is reimbursed at 100% rather than 80% of the reasonable charge (applicable copayment amounts are waived).

The beneficiary still has the option to rent or purchase DME. However, payment is made pursuant to the carrier's determination as to which method is cost-effective.

The prevailing and customary amounts for DME (both rental and purchase) are updated annually on July 1 (October 1, beginning with 1985). The amount by which the prevailing and customary charges increase is not limited by any economic index.

It has been recognized that the prevailing and customary charge amounts for DME reimbursed on a purchase basis are not well established in certain areas. As a result, the Secretary has instructed the carriers to use other methods when there are insufficient actual charge data for determining the customary or the prevailing charge in the locality.

Suppliers are able to sign participating agreements with the Secretary whereby they agree to accept assignment for all medicare claims for a year. Nonparticipating suppliers can choose on a chaim by claim basis whether or not to accept assignment.

Explanation of provision.—(a) The bill would set new reimbursement limits on rented durable medical equipment. In determining medicare's customary and prevailing charges for rented DME during FY 1986, the Secretary would allow an increase of no more than one percent over the level set for rented equipment furnished beginning July 1, 1984.

(b) Medicare payment for durable medical equipment provided on a rental basis would only be made on the basis of mandatory assignment, i.e., the supplier would be required to accept medicare's allowable charge as his or her full charge and could collect from the beneficiary no more than the applicable deductible and coinsurance.

(c) For DME items furnished on or after October 1, 1986, the bill would limit the increase in prevailing charges for rental and purchase to no more than the Consumer Price Index for all urban consumers.

The Committee intends that the Secretary, in applying the CPI index to the prevailing charges for purchased equipment for FY 1987, provide for an adjustment where it appears that the indexed charges for a particular item would result in significantly inappropriate amounts, in accordance with her authority under the bill's provisions relating to "inherent reasonableness" or charges.

Effective date.—Paragraph (a) would be effective with respect to items or supplies furnished on or after October 1, 1985.

Paragraph (b) would be effective with respect to items or supplies furnished on or after January 1, 1986.

Paragraph (c) would be effective with respect to items or supplies furnished on or after October 1, 1986.

7. Payment for assistants at surgery for certain cataract operations and other operations (sec. 147 of the bill)

Present law.—Currently, medicare covers assistants at surgery during routine cataract operations. Their services are considered reasonable and necessary if it is the generally accepted practice among opthalmologists in the local community to use an assistant at surgery. Some medicare carriers restrict coverage of assistants at surgery to cases where medical necessity is established.

Explanation of provision.—The bill would deny medicare payment for assistants at surgery for routine cataract operations. In cases where complicating medical conditions exist, the Secretary would be required to establish procedures by which the primary surgeon could request prior approval from the PRO for the use of an assistant.

The assistant at surgery (or someone on his or her behalf) would be prohibited from billing medicare or the beneficiary for services which did not receive a prior approval. In addition, the primary surgeon (or someone on his or her behalf) would be prohibited from including charges for the assistant in his or her bill for services. The proposal would give the Secretary the authority to impose civil monetary penalties or assessments, or exclusion for up to five years from the medicare program, or both, in order to enforce this provision and to ensure that beneficiaries are protected from additional out-of-pocket costs.

The Committee reviewed the findings of the Office of the Inspector General, HHS, which stated that the use of an assistant at surgery was not medically necessary in most situations. This finding was based on the practices of many primary ophthalmic surgeons who do not use such assistants. In addition, several medicare carriers currently restrict coverage of assistants at surgery.

The Secretary would be required, after consultation with the Prospective Payment Assessment Commission as reconstituted under the bill, to develop and report to Congress by April 1, 1986, recommendations and guidelines regarding other surgical procedures for which an assistant at surgery generally is not medically necessary. The Secretary would be required to include in this report procedures by which the primary surgeon could request prior approval from an appropriate entity for the use of an assistant at surgery when prior approval is required for these other surgical procedures.

Effective date.—This provision would be effective with respect to services performed on or after October 1, 1985.

8. Limitation on medicare payment for post-cataract surgery patients (sec. 148 of the bill)

Present law.—Medicare part B pays for certain combinations of prosthetic lenses, if determined to be medically necessary by the physician, i.e., cataract contact lenses and eyeglasses. Generally, part B carriers are authorized to replace prosthetic lenses without a physician's order in cases of loss or irreparable damage and when supported by a physician's order in cases of a change in the pa-

tient's condition. Currently, there are no uniform limits on the number of replacements for which medicare will provide reimbursement.

Physicians can bill medicare for services related to cataract surgery in two ways: (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability; or (2) separate codes for the lenses and for the physician's services.

Explanation of provision.—With respect to replacement of lost or damaged prosthetic lenses, the bill would limit medicare reimbursement as follows:

(1) cataract eyeglasses: one replacement each year;

(2) cataract contact lenses; one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year. The Secretary will determine the "years" over which these limitations will apply and anticipates the possibility that calendar years will be used.

The Secretary would be required to provide for separate payment amount determinations for the prosthetic lenses and for the related professional services, and to apply inherent reasonableness guidelines, in accordance with a separate provision of the bill, in determining reasonableness of charges for prosthetic lenses.

The Committee accepted the recommendations of the General Accounting Office which suggested the need for uniform limits for the replacement of such lenses. The Committee believes that these limits will ensure that benefits are uniformly applied.

The Committee intends, however, that the Secretary would not apply these limits where replacement of such lenses is the result of either a change in the patient's condition (and is supported by a physician's order) or of the natural wearing out of a lens.

Effective date.—The bill would be effective for items or services furnished on or after October 1, 1985.

9. Demonstration of preventive health services under medicare (sec. 149 of the bill)

Present law.—Medicare does not generally provide coverage for preventive health services.

Explanation of provision.—The Secretary of HHS would be required to fund at least five demonstrations, under the auspices of schools of public health, to determine whether and how it would be cost-effective to include preventive services as a medicare benefit.

Services to be made available to beneficiaries would include health screenings, health risk appraisals, immunizations, counseling and instruction on such matters as diet and nutrition, reduction of stress, exercise, sleep regulation, prevention of alcohol and drug abuse and mental health disorders, self-care, and smoking reduction.

Within three years, the Secretary would be required to submit a report to Congress describing the demonstrations in progress. Within five years the Secretary would be required to submit a final report that would evaluate the costs and benefits of providing such services and recommend whether specific preventive services should be included as a medicare benefit.

Effective date.—The provision would be effective on October 1, 1985.

D. Private Health Insurance Continuation

1. Temporary extension of coverage at group rates for family members of deceased, divorced or medicare-ineligible workers (sec. 161 of the bill)

Present law.—Under current law, there are no Federal requirements that employer-based group health insurance plans provide continuation or conversion options for any individuals who lose coverage in the health plan under any circumstances.

Explanation of provision.—The Committee is concerned with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay. Since 1977, the number of Americans without any health insurance coverage has increased by 40%, from twenty-five million people to thirty-five million people, according to a study conducted by the Department of Health and Human Services. At the same time that the number of Americans without health insurance is climbing, the traditional commitment of our country's hospitals to provide charity care is eroding. According to the American Hospital Association, one in every seven community hospitals adopted explicit limits on charity care in 1982 and 1983 alone.

In an effort to provide continued access to affordable private health insurance for some of these individuals, the Committee has proposed the following legislation.

The bill would amend Section 162 of the Internal Revenue Code to deny the business tax deduction for a group health plan of any employer who fails to include in the plan a continuation option to (1) a widowed spouse and dependent children, (2) a divorced or separated spouse and dependent children, or (3) a medicare ineligible spouse and dependent children.

A five-year continuation option would be available to the above groups after which time they would be offered the right to convert to an individual policy. The option of electing continuation coverage would be offered during a period that begins when the individual otherwise would lose coverage under the group health plan (the termination date), lasts at least 60 days, and ends not earlier than 60 days after the date the individual is notified of his continuation coverage rights by the group plan or the termination date, whichever date is later.

The bill would allow a spouse or former spouse who has been a qualified beneficiary under the group plan to elect continuation coverage on his or her own behalf and on behalf of the qualified dependent children.

The coverage provided would not be conditioned on any physical examination or other evidence of insurability and would be identical in scope to the coverage provided under the group plan to similarly situated individuals in the group.

Coverage would be cancelled during the five-year period if the employer ceased to provide any group health plan to employees, the qualified beneficiary did not pay the premiums or became cov-

ered under another group policy or medicare, or if the qualified beneficiary remarried and became or could become covered under the new spouse's group health plan. The covered dependent child would lose coverage upon no longer meeting the plan's defintion of a dependent child.

The qualified beneficiary would be required to pay both employer and employee shares of the premium costs, although the employer could assume the employer share if it wanted to. To prevent any gap in coverage, the qualified beneficiary who elects continuation coverage would be permitted to pay within 45 days of election of continuation coverage, for any premium owed for the preceding period—from the point of which coverage would otherwise have ended. The total premium charged by a group health plan for the continuation coverage would not exceed the sum of the employer and employee premiums generally charged to similarly situated beneficiaries. In order to protect the group plan from any increased costs due to the continuation of individuals under this bill, the total of all premiums charged by the plan in any plan year may be based upon reasonably anticipated community costs for such plan year of the entire pool of insured employees and other qualified beneficiaries under the plan, including persons receiving continuation coverage.

During the 180 days preceding the end of five years of continuation coverage, a qualified beneficiary would have the right to enroll under a conversion health plan, if such a conversion option is otherwise generally available to beneficiaries of the plan.

In accordance with regulations of the Secretary of the Treasury, the group health plan would provide written notice to each covered employee and spouse (if any), explaining the continuation and conversion options contained in the bill. The covered employee would be required to notify the group health plan administrator of any change in family status, i.e., separation, divorce or medicare eligibility, and the employer would be required to notify the group health plan administrator in case of the death of the covered employee, which would trigger eligibility for continuation coverage. Within 14 days after such notification, the administrator would be required to notify the affected qualified beneficiary of the date coverage would normally terminate and of the qualified beneficiary's right to elect continuation coverage and the election period during which the qualified beneficiary could exercise that right.

Effective date.—In general, the provision is effective for plan years beginning on or after January 1, 1986. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements, the bill would not apply to plan years beginning before the earlier of the date on which the last of the collective bargaining agreements relating to the plan terminates or January 1, 1987.

MEDICARE HEARING AND APPEALS PROCESS

It has been thirteen years since this Committee has looked substantively at medicare's appeals procedure. Since that time the medicare program has undergone major changes. Inpatient hospital services that were reimbursed on a cost basis are now mostly

subject to the prospective payment system. An increasing amount of services once provided only on an inpatient basis are now being provided in ambulatory settings.

As a result of these changes the Committee believes that the current hearing and appeal procedure under medicare needs to be reviewed. The Committee wants to ensure that adequate procedural safeguards are provided to program beneficiaries, suppliers and providers.

The Committee will, therefore, hold hearings on this issue and, if warranted, take legislative action.

PHYSICAL THERAPISTS

Under current law, part B covers the services of a qualified physical therapist in independent practice when furnished by him or under his direct supervision in his office or in the patient's home. These services must be prescribed by a physician and furnished pursuant to a written plan of treatment established by a physician or a qualified physical therapist.

The Secretary is required, under present law, to establish conditions that an independently practicing physical therapist must meet in order to receive medicare reimbursement. The Secretary, by regulation, requires that a physical therapist in independent practice maintain an office or office space with the necessary equipment to provide an adequate program of physical therapy. This requirement is applied even to those therapists who operate exclusively in the beneficiary's home.

The Committee believes that the requirement that independently practicing physical therapists who operate exclusively in beneficiaries' homes maintain fully-equipped offices is unnecessary. The Committee therefore intends that the Secretary eliminate this regulatory requirement.

HOME HEALTH AGENCY SUPERVISION

The medicare law requires that a physician or registered nurse supervise patient care services provided by a home health agency. Some have urged that other health care professionals be permitted to perform this supervisory role.

The Committee believes it desirable for the Secretary tc examine the question of whether other health care professionals, (e.g., physical therapists, occupational therapists, and speech-language pathologists) may be qualified to perform the supervisory role. The Committee expects the Secretary to report to Congress with recommendations on the appropriations and feasibility of allowing other health care providers to perform the supervisory role for a home health agency. The Committee intends that such report include recommendations on the appropriateness of allowing other health care professionals to supervise the administrative services provided by a home health agency. Further, the Secretary would be required to specify criteria and conditions for which they could fulfill the supervisory role.

The report would be due April 1, 1986.

TITLE II—TRADE AND CUSTOMS LAWS AMENDMENTS

PART A—TRADE ADJUSTMENT ASSISTANCE

Part A of Title II of the bill contains the provisions of H.R. 1926, as amended in the nature of a substitute by the Committee on Ways and Means. Part A reauthorized the trade adjustment assistance (TAA) programs for workers and firms under the Trade Act of 1974, as amended, for four years until September 30, 1989 and amends certain provisions of these programs concerning coverage and administration. The TAA program for both workers and firms terminate by statute on September 30, 1985.

The program for *workers* under current law contains the following principal elements:

—Groups of workers petition the Secretary of Labor (Employment and Training Administration) for certification of eligibility to apply for TAA benefits based on whether increased imports "contributed importantly" to significant worker layoffs, or the threat thereof, and to production and/or sales declines in the workers' firm or subdivision of a firm. Only workers in firms or subdivisions producing a product "like or directly competitive" with the imported article are eligible. (section 101 of H.R. 1926 as reported amends these provisions)

—Certified workers then apply individually to State employment security agencies for the following TAA benefits:

1. Weekly cash payment entitlements (trade readjustment allowances (TRA) if certain employment history requirements are met. (section 102 of H.R. 1926 as reported amends these provisions)

The TRA benefits are equal to the worker's most recent UI weekly benefit after the worker has exhausted his regular UI, extended UI benefits (EB) and any Federal Supplemental Compensation (FSC) entitlements. A worker cannot receive more than 52 weeks of UI and TRA benefits combined, except workers in approved training may receive up to 26 additional weeks to complete training if application for such benefits is made within 210 days after the worker's certification or first layoff, whichever is later. Basic TRA benefits can be paid only during the 52-week period following the week in which the worker has first exhausted regular UI; additional benefits while in training are payable only during the 26-week period following the last week of entitlement to basic TRA or beginning with the first week of training if it is approved after the last week of basic TRA entitlement. (section 103 of H.R. 1926 as reported amends these provisions)

2. Approved training under other Federal programs if certain conditions are met. (sections 104 and 105 of H.R. 1926 as reported amends these provisions)

3. Job search and relocation allowances if certain conditions are met.

All TAA benefits are funded from general revenues through annual appropriations under an authorization of "such sums as may be necessary." In fiscal year 1985, the projected cost of TRA entitlements is $45 million under the Federal Unemployment Benefits and Allowance (FUBA) account; $26 million has been appro-

priated specifically for training costs and job search and relocation allowances.

The program for *firms* under current law consists of the following principal elements:

—Individual firms petition the Secretary of Commerce (International Trade Administration) for certification of eligibility to apply for TAA benefits based on whether increased imports "contributed importantly" to significant worker layoffs, or the threat thereof, and to production and/or sales declines of the firm. (section 201 of H.R. 1926 as reported amends these provisions)

—A certified firm may apply for and receive assistance if the Secretary of Commerce approves its economic adjustment proposal and the firm does not have reasonable access to private financing.

—TAA to individual firms consists of (1) technical assistance to prepare petitions and to prepare and/or implement economic adjustment proposals (usually through regional Trade Adjustment Assistance Centers), and/or (2) financial assistance in the form of direct loans (up to $1 million at Treasury cost of borrowing) or loan guarantees (up to $3 million with maximum 90 percent guarantee). (sections 202–205 of H.R. 1926 as reported amends these provisions).

—Industry-wide technical assistance may be provided for new product, process, or export development up to $10 million annually per industry.

All firm TAA benefits are funded from general revenues through annual appropriations to the International Trade Administration under an authorization of "such sums as may be necessary." The current appropriation level for the program in fiscal year 1985 is $25.0 million.

Subpart I. Worker Adjustment Assistance

1. Group Eligibility Requirements (sec. 201 of the bill)

Present law.—Section 222 of the Trade Act of 1974 contains the criteria for certification by the Secretary of Labor of groups of petitioning workers as eligible to apply for TAA benefits.

Under these criteria, a petitioning group of workers is certified eligible to apply for TAA benefits if the Secretary of Labor determines that increased imports of articles like or directly competitive with articles produced by a firm or subdivision "contributed importantly" to an actual or threatened layoff of a significant number or proportion of workers and to absolute declines in the sales and/or production of that firm or subdivision.

Reasons for change.—Because the statute requires that increased imports be an important cause of layoffs, the current program covers workers laid off as a result of plant relocations overseas if increased imports of the particular article produced by that firm or subdivision precede its closing and move. The amendment would enable workers to be certified who are equally impacted by actual or threatened layoff because of relocation of production functions of the firm or subdivision overseas irrespective of whether relocation replaces exports or results in increased imports. However, the

firm or plant closing must be accompanied by the transfer of its production functions overseas; the mere closing of a company or plant would not meet the requirements for certification.

Explanation of provisions.—Section 201 of the bill amends section 222 of the Trade Act of 1974 by adding a new paragraph (2) to expand certification coverage to workers in a firm or subdivision who are laid off or threatened with layoff "by reason of the relocation of the production functions of that firm or subdivision to a foreign country or instrumentality."

Effective date.—The amendment applies to petitions for certification filed after September 30, 1985.

2. Qualifying Requirements (sec. 202 of the bill)

Present law.—Section 231(a) of the Trade Act of 1974 requires that an individual worker covered by a certification have at least 26 weeks of employment at weekly wages of $30 or more in adversely affected employment during the 52 weeks preceding layoff to be eligible for TRA benefits. The purpose of these requirements is to demonstrate sufficiently long-term attachment to the labor force to warrant additional unemployment benefits. As amended in 1981, qualifying 26 weeks may include:

Up to 3 weeks of employer-authorized leave for vacations, sickness, injury, maternity, military, or to serve as fulltime union representative; or

Up to 7 weeks of disability covered by workmen's compensation; or

Up to 7 weeks combining disability and leave, of which not more than 3 weeks may be employer-authorized or union leave.

Reasons for change.—The amendment made by section 202 of the bill are intended to ensure that workers with many years of service are not denied TRA eligibility simply because they did not have the requisite number of weeks actually on-the-job in the particular one-year period preceding their layoff by reason of events beyond their control or authorized leave to which they were entitled.

Explanation of provision.—Section 202 of the bill amends section 231(a)(2) of the Trade Act of 1974 to increase the maximum number of weeks that may be counted as weeks of employment toward the 26-week minimum preceding layoff. The number of qualifying weeks would increase from 3 to 7 for employer-authorized or union leave; from 7 to 26 weeks for disability; and from 7 to 26 weeks combining disability and leave, of which authorized leave cannot exceed 7 rather than the present 3 weeks.

Effective date.—The amendment applies to petitions for certification filed after September 30, 1985.

3. Limitations on Trade Readjustment Allowances (sec. 203 of the bill)

Present law.—Under section 233(a)(2) of the Trade act of 1974, as amended in 1981, a worker may collect basic trade readjustment allowances (TRA) only during the 52-week period beginning with the week immediately following the first week covered by the certificate with respect to which the worker has first exhausted all rights to regular unemployment compensation.

Reason for change.—Delays in the certification process as well as temporary recalls cause some workers to forfeit some benefits because the collection period has expired prior to their exhaustion of weeks of TRA entitlement. The purpose of the amendment is to enable workers to collect the full amount of TRA benefits to which they are entitled.

Explanation of provision.—Section 203 of the bill amends section 233(a)(2) of the Trade Act of 1974 to extend the collection period for basic TRA benefits from 52 to 104 weeks following exhaustion of regular unemployment compensation.

Effective date.—The amendment takes effect on October 1, 1985.

4. Worker Training (Sec. 204 of the bill)

Present law.—Section 236(a) of the Trade Act of 1974 authorizes the Secretary of Labor to approve training for a certified worker if he determines that five statutory conditions are met. One of these five requirements is a determination that there is a "reasonable expectation of employment" following completion of such training.

Reasons for change.—The purpose of the amendment is to ensure that the absence of a prior guarantee of employment immediately upon completing training is not used as a basis for denying training approval. The provision is consistent with current Department of Labor regulations.

Explanation of provision.—Section 204 of the bill amends section 236(a) to add the stipulation that a "reasonable expectation of employment" does not require that employment opportunities for a worker be available or offered immediately upon the completion of training.

Effective date.—The amendment applies to workers covered under certifications issued after September 30, 1985.

5. Agreements with States Regarding Training (sec. 205 of the bill)

Present law.—Section 239(a) of the Trade Act of 1974 requires State employment security agencies, under cooperating agreements with the Secretary of Labor, to receive applications, make payments of TAA benefits, and afford adversely affected workers who apply for payments testing, counseling, referral to training, and placement services.

Reasons for change.—The State employment security agencies should emphasize to workers of the importance of training to their adjustment and encourage workers to seek training at as early a stage as possible. Imposing such obligations on the State agencies would underscore the need for workers to seriously consider training rather that treat TRA benefits as extended unemployment compensation. Early entry into training also better ensure that necessary TRA income maintenance will be available to workers for up to one year coincident with their training period.

Explanation of provision.—Section 205 of the bill adds a new paragraph (2) to section 239(a) of the Trade Act of 1974 to require that each cooperating State agency advise each adversely affected worker to apply for training at the time the worker applies for TRA benefits. The provision also requires each agency, within 60 days after the worker applies for training, to interview and review

with that worker suitable training opportunities available under section 236.

Effective date.—The amendment takes effect on October 1, 1985.

Subpart II. Firm Adjustment Assistance

1. Petitions (sec. 211 of the bill)

Present law.—Under section 251(c) of the Trade Act of 1974, the Secretary of Commerce certifies a firm eligible to apply for adjustment assistance if he determines that a significant number or proportion of the workers are laid off or threatened with layoff, sales and/or production of the firm have decreased absolutely, and increased imports of articles like or directly competitive with articles produced by the firm contributed importantly to the layoffs and decline in sales and/or production.

Reasons for change.—Under current law, total sales and/or production of the firm must have declined absolutely. The amendment would enable firms which lose production or sales in a significant product line because of increased imports to receive assistance even though their total performance, at least on a temporary basis, has not declined. The purpose of the provision is to address import adjustment problems early, particularly of young firms, for example, in high technology industries, with production histories of two years or less which may face rapid import penetration.

Effective date.—The amendment applies to petitions for certification filed after September 30, 1985.

2. Approval of Adjustment Proposals (sec. 21 of the bill)

Present law.—Section 252(b) of the Trade Act of 1974 authorizes technical assistance to certified firms to implement acceptable adjustment proposals; section 252(c) authorizes technical assistance to certified firms to help them prepare adjustment proposals. Section 253 authorizes technical assistance to assist firms in preparing petitions for certification, as well as to certified firms to prepare and implement adjustment proposals.

Explanation of provision.—Section 212 of the bill contains technical amendments to section 252 to remove inconsistences with section 253 and to clarify that three forms of technical assistance are available to firms under the program as specified in section 253.

Effective date.—The amendment takes effect on October 1, 1985.

3. Technical Assistance (sec. 213 of the bill)

Present law.—Section 253(b)(2) of the Trade Act of 1974 limits the U.S. Government share to 75 percent of the cost of technical assistance (petition preparation, adjustment proposal preparation, adjustment proposal implementation) provided by private individuals, firms, or institutions.

Reasons for change.—Removing the matching share requirement on firms for assistance in preparing petitions for certification and in preparing economic adjustment proposals would remove the financial burden on firms for technical assistance which may not be followed by actual implementation assistance under the program.

Explanation of provision.—Section 213 of the bill amends section 215(b)(2) of the Trade Act of 1974 to remove the 75 percent limita-

tion on the U.S. Government share of the cost of technical assistance provided to assist firms in preparing petitions for certification or in preparing economic adjustment proposals (including diagnostic surveys). The matching share requirement would continue to apply to assistance for implementing economic adjustment proposals.

Effective date.—The amendment takes effect on October 1, 1985.

4. Financial Assistance (sec. 214 of the bill)

Present law.—Section 254(b) of the Trade Act of 1974 authorizes TAA loans or loan guarantees only for the purpose of making funds available to the firm for fixed assets or for working capital to implement its adjustment proposal.

Explanation of provision.—Section 214 of the bill amends section 254(b) to clarify that single loans or a combination of loans or loan guarantees may be made for mixed uses.

Effective date.—The amendment takes effect on October 1, 1985.

5. Protective Provisions (sec. 215 of the bill)

Present law.—Section 258(d) of the Trade Act of 1974 prohibits the provision of financial assistance to any firm unless the owners, partners, or officers execute an agreement binding them and the firm for two years after the assistance is provided not to employ or retain for professional services any person who on the date the assistance was provided or within one year prior thereto occupied a position or engaged in activities involving discretion in providing the assistance.

Explanation of provision.—Section 215 of the bill amends section 258(d) of the Trade Act of 1974 to require that the agreement bind the owners, partners or officers on behalf of the firm but not themselves individually.

Effective date.—The amendment takes effect on October 1, 1985.

Subpart III. Extension of Adjustment Assistance (sec. 221 of the bill)

Present law.—Section 285 of the Trade Act of 1974, as amended in 1983, terminates the TAA programs for workers and firms on September 30, 1985.

Reasons for change.—Trade adjustment assistance programs for workers and firms were originally enacted under the Trade Expansion Act of 1962. Congress established these special programs in the belief that the particularly severe nature of economic dislocation that may result from changes in trade policy adversely affecting employment prospects in entire industries or geographic regions necessitated greater benefits and adjustment measures than available under regular programs. Congress also believed that the Federal Government should bear the responsibility of aiding particular segments of industry and labor dislocated by national policies to liberalize trade for the benefit of the country as a whole. Trade adjustment assistance programs would also provide an alternative policy to import restrictions as a temporary relief measure.

The criteria for worker and firm certification and the benefit levels for workers were considerably liberalized under the Trade

Act of 1974. The worker program was amended extensively again under Title XXV of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) to reduce cash benefit costs and to reorient the program from primarily income maintenance to adjustment of the longer-term and permanently unemployed. Relatively minor changes were also made at that time in the program for firms, including provisions for industry-wide technical assistance. Further amendments were made to certain provisions of the program in Public Law 98-120 and in the Deficit Reduction Act of 1984 (Public Law 98-369).

The Subcommittee on Trade of the Committee on Ways and Means has held three hearings on TAS this year, including two field hearings to obtain on-site information on the operation and effectiveness of the worker and firm programs. Based on that testimony the Committee believes that the original rationale for TAA remains valid and that reauthorization of both TAA programs is warranted. Budgetary resources and the types of benefits available to workers and firms under other Federal programs are inadequate to deal with the magnitude and nature of problems that can result from increased imports competition. The record U.S. trade deficit and structural adjustment problems in major domestic industries necessitate the continuation of the TAA programs specifically designed to address trade-related economic dislocations as an alternative to import restrictions.

Explanation of provision.—Section 221 of the bill amends section 285 to reauthorize the TAA programs for both workers and firms for four years until September 30, 1989.

Subpart IV. Effective Dates (sec. 231 of the bill)

Section 231 of the bill contains the effective dates of the various amendments to the program as described in each section above.

PART B—AUTHORIZATION OF APPROPRIATIONS FOR TRADE AND CUSTOMS AGENCIES

Part B of Title II of the bill contains the provisions of H.R. 2250, as amended and ordered reported by the Committee on Ways and Means. Part B combines three separate trade agency authorizations under the jurisdiction of the Committee, and makes certain changes in customs procedures.

Section 241 of the bill authorizes appropriations of $28,901,000 for the U.S. International Trade Commission (ITC) for fiscal year 1986, the amount requested by the ITC, and authorizes use of funds for rental of conference space in the District of Columbia and minimal representation expenses.

Section 242 of the bill authorizes $769,067,000 in appropriations for the U.S. Customs Service for fiscal year 1986 of which $50,425,000 is for the operation and maintenance of the air interdiction program. These figures reflect two Committeee amendments to the bill as introduced—one authorizes and additional $27.9 million earmarked to fund 800 additional customs officers in designated line positions, and the other reduces the authorized level for the air program by $10 million with the total Customs authorization being reduced by $5 million. The bill as amended in-

creases the authorization level for the U.S. Customs Service by $69.6 million over that requested by the Administration. Section 242 also limits to $14 million the amount of authorized funds which Customs may expend for the implementation of the Operation EXODUS program; authorizes appropriations of up to $8 million from the Customs Forfeiture Fund for appropriate expenditures; and authorizes appropriation of such funds as may be necessary (up to $75,000 per airport) to provide service to airports operated on a reimbursable basis under section 236 of the Trade and Tariff Act of 1984. The bill also directs that any savings in salaries and expenses resulting from administrative consolidation be used to increase the number of Customs' line operational positions.

Further, section 242 would preclude the closing of any port of entry which processed more than 2,500 entries and collected more than $1.5 million in revenues during FY 1985 and would preclude any proposed final rule revising or eliminating sureties on customs bonds from taking effect until 90 calendar days after Customs' submission of a report to Congress.

The Committee also adopted an amendment to prevent the Customs Service from reducing the number of drawback liquidation centers to fewer than four centers and an amendment requiring the Secretary of Treasury to provide the Committee on Ways and Means and the Senate Committee on Finance with a written comparative assessment of the suitability of available aircraft for the Customs Air Program 60 days before spending any funds for research and development of avionics for the P-3 aircraft. Finally, a Committee amendment directs that the General Accounting Office undertake a comprehensive study of Customs' air detection and interdiction capability and submit such study to the Committee on Ways and Means and the Senate Committee on Finance along with its recommendations before Treasury can submit its comparative study. Any purchases made subsequent to these studies must be made on a competitive bid basis.

Section 243 of the bill authorizes $13,582,000 for the U.S. Trade Representative (USTR) for fiscal year 1986, the same amount as current appropriations for fiscal year 1985.

1. U.S. International Trade Commission (sec. 241 of the bill)

Present law.—The Trade Act of 1974 (Public Law 93-618) provides that the estimated expenditures and proposed appropriations for the International Trade Commission shall be included in the budget submitted by the President to the Congress without revision and amended section 330 of the Tariff Act of 1930 to require that that annual authorization of appropriations for the Commission be established by law.

Because of the unique role of the Commission as a quasijudicial and independent agency designed to provide trade expertise to both legislative and executive branches of Government, the Congress provided that the budget of the ITC would not be subject to the control by the Office of Management and Budget, but would instead be submitted directly to the Congress. The Committee believes that this budgetary independence has been useful in insuring the independence and objectivity of the Commission.

Explanation of provision.—Section 241 amends paragraph (2) of section 330(c) of the Tariff Act of 1930 to authorize an appropriation of $28,901,000 for the ITC for fiscal year 1986. This is the amount requested by the ITC. Section 241 also provides authority for the Commission (1) to expend funds for rental of conference rooms in the District of Columbia and elsewhere as necessary; and (2) to use up to a maximum of $2,500, subject to approval by the Chairman of the Commission, for reception and entertainment expenses. The funds which may be used for these purposes are included in the $28,901,000 total authorization for the Commission in fiscal year 1986.

The amount authorized by section 1 is $3,522,000 more than the amount for fiscal year 1985, assuming enactment of the fiscal year 1985 pay increase supplemental appropriations. The increase is necessary to meet required nondiscretionary cost increases, and to fully fund the additional 44 full-time permanent positions approved in the fiscal year 1984 supplemental appropriation. The number of permanent positions will remain 482, the level authorized by Congress last year.

Section 241 does not include any funds for the relocation of the ITC to a new building since a definite site or relocation that has not been determined. Public Law 98–573 transfers the Commission's current headquarters building to the Smithsonian Institution and requires the General Services Administration (GSA) to relocate all Commission functions to a single downtown facility. The Commission hopes to relocate sometime during FY 1986, and will likely be requesting additional funding for FY 1986 or a supplemental appropriation for FY 1985 at such time as the relocation becomes more definite.

After careful review, the Committee supports the Commission's budget request. The Commission's crucial role in deciding import relief matters and rendering recommendations to the President is of critical importance to the operation of a transparent, fair, and effective trade policy. In addition, the Commission's responsibility under the Trade Agreements Act of 1979 to examine and decide injury questions in antidumping and countervailing duty cases has resulted in a dramatic increase in caseload. These functions are essential in maintaining an effective regime over injurious import competition and unfair trade practices. Finally, the number and variety of requests from Congress for special studies and other fact-finding and technical services has steadily increased. These studies are of paramount concern to this Committee, since they address special trade problems or issues relevant to pending or anticipated legislation.

2. U.S. Customs Service (sec. 242 of the bill)

Present law.—The Customs Procedural Reform and Simplification Act of 1978 (Public Law 95–410) provides for the annual authorization of appropriations for the U.S. Customs service. The Customs Service submitted a consolidated authorization request of $699, 527,000, which included $639,102,000 for salaries and expenses and $60,425,000 for operations and maintenance of the Customs air program. The Administration's request proposed cuts of about 887 Customs positions.

The bill, as introduced, provided a fiscal year 1986 Customs budget of $746,167,000, an amount $46.6 million higher than the Administration's request. This amount would have allowed the Customs Service to maintain current operating levels in fiscal year 1986 by restoring the proposed cut of 887 positions and adding back the 5 percent salary cut which was built into the Administration's proposed budget.

Reasons for Change.—Section 2(a) of H.R. 2250, as amended by the Committee, amends section 301(b) of that Act to authorize appropriations of $769,067,000 for the U.S. Customs Service in fiscal year 1986. This increases by about $69.5 million the amount requested for Customs by the Administration. As amended, the bill would not only restore the proposed cut of 883 positions, but would increase the authorization level by $27.9 million for the addition of 800 new front-line customs officers over and above the agency's current number of personnel—500 inspectors, 150 import specialists, 100 patrol officers and 50 special agents. The Committee believes that this increase is necessary for Customs to cope with the ever-increasing workload of passengers and cargo and to enhance Customs' narcotics enforcement capabilities. While the Committee applauds the efforts of the U.S. Customs Service to do more with less, the Committee seriously questions whether current staffing levels at the U.S. Customs Service are sufficient to effectively carry out its mandate of collecting customs revenues and enforcing a number of laws designed to protect our borders from illegal and fraudulent importations.

In the 10-year period from 1976 to 1985, Customs' staff has increased by only 38 positions from 13,380 to 13,418, while the value of imports over that time period has more than tripled from $113.8 billion in 1976 to approximately $358 billion in 1985. There has also been an alarming volume of fraudulent imports entering the country. According to one study, it is estimated that about $40 billion in unreported and counterfeit goods illegally enter the United States each year resulting in $3 billion in lost revenues from duties and a direct loss of sales for American companies of billions of dollars. Further, the House Select Committee on Narcotics Abuse and Control estimates that in 1984, 85 tons of cocaine, 10 tons of heroin, 15,000–16,000 tons of marijuana, and 200 tons of hashish entered the United without being detected. A dramatic increase in front-line Customs personel is essential to address these serious problems.

The Committee is acutely aware of the need to control our fiscal deficit in order to reduce the value of the dollar and help U.S. companies to compete abroad. However, cutting the staff of the Customs Service would clearly be counterproductive in this regard. Customs is a revenue-producing agency and it is expected that the staffing level provided for under the Committee bill will generate increased customs revenues ranging from $50 million in fiscal year 1986 to $750 million in fiscal year 1987. This revenue increase is reflected in the House Budget Resolution and substantiated by the Congressional Budget Office.

The Committee therefore believes that it is both necessary and appropriate to authorize 800 additional positions above current levels, both to ensure better enforcement of our trade laws and to

provide much needed revenue. Moreover, the Committee fully expects the increase in personnel to be permanent, and would consider further increases in manpower in future years if necessary. Therefore, it is expected that the revenue gain would extend beyond FY 1986 to future years.

The Commissioner of Customs should allocate the new personnel authorized by this bill to those port facilities where the volume and complexity of imports is greatest. In this regard, the Commissioner shall give particular attention to ensuring proper enforcement of steel, textile, and garment import restraints in allocating these personnel. Further, special attention should be given to assigning the personnel provided by the Committee amendment to ports and facilities where the provision of customs service can result in significant savings to the taxpayer through lower costs to other Federal agencies (for example, the clearance of military flights at lower cost airports such as Oakland, California).

Expalantion of provisions.—in addition to the change in authorization levels discussed above, a number of the provisions affecting the Customs Service are contained in section 242, as described below.

Use of savings resulting from administrative consolidation.—Because of the problems discussed above related to the shortage of front-line customs personnel, the Committee approved a provision directing that any savings in salaries and expenses resulting from the consolidation of administrative functions within the Customs Service shall be used to strengthen the commercial operations of the Customs Service by further increasing the number of inspector, import specialist, and other line operational positions. The Committee supports Customs efforts to streamline administrative functions, such as the proposal which Customs is currently implementing to centralize personnel and financial functions, which is expected to result in a savings of 280 positions. However, the Committee strongly believes that such initiatives will have a beneficial effect on the operations of the Customs Service only if the savings resulting therefrom are translated into a strengthening of Customs' frontline personnel. In the interest of fariness to dedicated Customs employees and to strenthen the morale of the Customs Service, Customs is encouraged to give qualified displaced administrative personnel the opportunity to compete for the operational positions created by any such administrative consolidation.

Operation Exodus.—Section 242(a) of the bill limits to $14 million the amount of authorized funds which Customs may expend for operation Exodus and any other export control programs. A similar limitation passed the House April 16, 1985, in the amendments to the Export Administration Act. The Committee believes that the amount provided will be sufficient to operate an effective program in conjunction with the Department of Commerce and the Department of Defense which have leading jurisdiction over the administration and enforcement of export control laws. The Committee intends that Customs coordinate its export control efforts with these agencies as well as with the Drug Enforcement Administration, the Coast Guard, and other law enforcement agencies which have a role in monitoring and investigating violations of export controls.

As was the case last year, the Committee is concerned that the administration and enforcement of export control laws cause hardship, incovenience, and loss of legitimate sales for U.S. exporters. It urges Customs to continue to reevaluate procedures for detecting violations in order to achieve a system which halts the illegal transfer of technology while imposing a minimum amount of burden and incovenience on legitimate American exporters.

Restriction on port closures.—Section 242(a) further precludes the Customs Service from closing any port of entry during fiscal year 1986 which during fiscal year 1985 processed not less than $1.5 million in customs revenues.

The U.S. Customs Service has testified before the Subcommittee on Trade that it hopes to convert some small underutilized ports to a reimbursable basis. This would mean that the local community serviced by the port would have to pay the Federal Government for a continued Customs presence. The Customs Service does not currently have the authority to require payment for its services, but is expected to request Congressional authorization to do so. However, in the absence of authority to convert the ports listed for proposed reimbursement, Customs retains the authority to close these ports.

The Committee believes that the criteria which the Customs Service proposes to use to determine which ports would be converted are biased against interior ports not servicing international airports because the Customs Service is looking only at criteria relating to formal entries processed and international air arrivals and passengers cleared. It totally disregards the fact that a significant amount of cargo is cleared and substantial revenues are collected at a number of inland ports. This bill establishes meaningful and fairer criteria relating to total number of entries processed and total revenue collected in determining the future status of these ports.

This provision should have little impact on Customs' initiative to streamline its port operations. First of all, Customs has testified before the Subcommittee that it does not plan to close any ports in fiscal year 1986. Further, of the 226 ports which Customs is currently considering converting to a reimbursable basis if legislative authority is granted, only 11 would satisfy the criteria set out in this provision.

Customs air interdiction program.—The Committee adopted several amendments in section 242(a) relating to the operation of the Customs air interdiction program. The bill as introduced allocated $60,425,000, the Administration's request, for the operation of the air program. This would have amounted to a $16 million increase over that approved for fiscal year 1985. Under the Administration's proposal, $5 million of this increase would be used to fund research and development of a 360-degree radar for the P–3 aircraft. Another $4 million would be used to modify certain C–12 aircraft which Customs is expecting to receive on loan from the Department of Defense by outfitting them with detector radar and infrared sensors.

The Committee amendment reduces the funds available for operation of the air program to $50,425,000 and the total Customs authorization by $5 million. The amendment is intended to eliminate $5 million from the air interdiction authorization that was ear-

marked for research and development of a 360-degree radar and $5 million earmarked for modification of a DOD C-12 aircraft and to shift $5 million to the general salaries and expenses fund to enhance commercial operations. The amendment further provides that $5 million from the Customs Forfeiture Fund may be expended for modifications of this aircraft if the Service desires.

The amendment also would require the General Accounting Office (GAO) to complete a detailed study of the Customs Service's air interdiction capabilities and submit its report to the Committee on Ways and Means and the Senate Committee on Finance, as soon as possible, but not later than 12 months after enactment of this Act. Within 6 months after commencing the study, GAO is directed to consult with the Committees on its progress. Further, at least 60 days before expending any funds for further research and development or acquisition of avionics for the P-3 aircraft and related equipment and after the GAO report has been submitted to the Committees, the Secretary of Treasury must submit to the same Committees a written comparative assessment of the suitability of the P-3, E-2, or other appropriate aircraft for use in Customs' air interdiction program. Finally, any acquisition of additional aircraft for the air program must be subject to competitive bidding.

As the Committee responsible for overseeing the operation of the U.S. Customs Service, the Committee is concerned that the rapid expansion in the funding of the air program is occurring without adequate consideration of how these funds can be optimized to provide for the strongest possible air interdiction program.

For example, the Committee feels the Service has not investigated thoroughly enough the existing alternatives to spending $5 million in FY 1986 on research and development for a new radar system for the P-3 aircraft to be used in the air interdiction program. Since $5 million is only the first year cost of a development effort that could cost many millions more in later years, since there appears to be an existing system available, the E-2, and since a classified Navy study raises serious doubts about the suitability of the P-3 aircraft for Customs Service air interdiction, the Committee intends that the expenditure of funds for radar research and development be delayed until a comparative assessment of the life cycle costs and reliability and effectiveness of both systems is delivered to the Committee on Ways and Means and the Senate Committee on Finance. At the very least, life cycle costs should include the costs of procuring, operating, and maintaining the systems.

Consolidation of drawback liquidation centers.—Section 242(a) would also preclude the Customs Service from Consolidating the number of drawback liquidation centers to fewer than four centers. If a consolidation is undertaken, the Commissioner of Customs is directed to select the location of the remaining centers after taking into account the drawback volume at, and the geographic dispersion of, the respective centers being considered for consolidation.

"Drawback" refers to the process whereby importers are entitled, under 19 U.S.C. 1313, to a refund of duties originally paid on imported merchandise upon the exportation of domestically manufactured goods which are made from the imported merchandise or

made from other merchandise of the same class of kind legally substitutable for the imported merchandise.

Due to the specialized nature of drawback claims, the liquidation (processing) of drawback entries is currently accomplished by the Customs Service in only nine locations throughout the United States. The Customs Service on July 5, 1983, requested public comment on a proposal to reduce the number of drawback liquidation units and to centralize this function in one location.

The Committee is concerned that the reduction from nine drawback center to one would have a significant adverse impact on the trading community, particularly smaller firms, without resulting in any real cost savings or other benefits to the Customs Service. In fact, centralization could cause an increase in Customs' overall clerical burden and individual workloads and impede Customs' processing capabilities. The loss of Customs expertise at the closed locations is likely to restrict the availability of drawback presently enjoyed by small- to mid-sized firms as well as increase travel and related costs to all firms.

The Committee amendment was the result of a compromise which would permit the Customs Service to consolidate drawback locations if they determine that increased efficiencies would result. However, they could not consolidate to fewer than four locations.

Customs Forfeiture Fund.—Section 242(a) authorizes an appropriation of up to $8 million from the Customs Forfeiture Fund for the making of payments under section 613A of the Tariff Act of 1930 (10 U.S.C. 1613b). As amended by the Committee, this section also authorizes the Customs Service to expend up to $5 million out of the proceeds in the Fund for modification of aircraft (whether or not forfeited) for drug interdiction purposes.

The Customs Forfeiture Fund was established pursuant to section 213 of the Trade and Tariff Act of 1984 (Public Law 98-573). Prior to the enactment of this provision, the costs of handling each seizure had been deducted from the proceeds if any, of that seizure. However, in instances where proceeds were not sufficient to cover expenses, Customs had to cover the expenses out of its regular operating budget. The latter situation occurred frequently—by the time the seized property was forfeited, expenses for storage and other miscellaneous charges had exceeded the proceeds of the sale. Moreover, the net proceeds from one sale could not be used to offset the losses incurred from another sale.

Under the provisions of the Trade and Tariff Act, seized and forfeited currency and any proceeds beyond the expenses of seizure and forfeiture of merchandise are deposited into the Customs Forfeiture Fund. Customs is authorized to use these funds for expenses related to seizure; awards to informants; payment of liens related to seizures; equipping forfeited vessels, vehicles, and aircraft; payment of claims of "parties of interest to property disposed"; purchase of evidence; and destruction of drugs.

User fees at certain small airports.—Section 236 of the Trade and Tariff Act of 1984 (Public Law 98-573) authorizes the U.S. Customs Service to charge user fees for services at certain small airports where the volume or value of business is insufficient to justify the availability of customs services. The fee will be equal to the expenses incurred in providing the services. The legislation author-

izes Customs to begin charging a fee for services at the airport located at Lebanon, New Hampshire, and for up to four additional locations to be designated by the Secretary of Treasury. (The governor of the State in which such airport is located must also approve the designation.)

The fees which are collected at each airport will be deposited into an account within the Treasury of the United States that is specifically designated for that airport. The funds in the account as provided by appropriation acts, will only be available for expenditures relating to the provision of customs services at each airport including salaries and expenses of personnel employed to provide such services.

Section 242(a) would authorize the appropriation of such funds as may be necessary, up to $75,000 for each airport, for the provision of customs services at such airports.

Elimination of sureties on customs bonds.—Section 242(b) of the bill requires that both the House Committee on Ways and Means and the Senate Committee on Finance be informed before the Customs Service publishes a final rule revising any existing requirement for sureties on customs bonds set forth in 19 CFR part 113 and section 142.4. More specifically, the section directs the Commissioner of Customs to submit to the Committees a report containing (a) the text of the draft final rule; (b) an analysis of the revenue impact of the proposed revision; (c) a regulatory impact analysis; (d) the estimated cost benefit of the proposed revision to the Customs Service and to the importing community and an explanation supporting those estimates; and (e) a justification of any revision. Only after 90 calendar days of continuous session of Congress has passed after submission of such a rule and report to the Committees may Customs publish the final rule in the Federal Register.

For purposes of this section, continuous session of Congress would be broken only by an adjournment of the Congress sine die. However, the days when either House of Congress is not in session because of an adjournment of more than three days to a date certain would be excluded in the computation of the 90-day period. Thus, the effective period from notification to publication of the final rule may well exceed 90 calendar days.

The purpose of this provision is to give the Committee on Ways and Means sufficient opportunity to study any proposed revision in the existing Customs regulations which would revise or eliminate the requirement for sureties on customs bonds before it takes effect. The Committee is concerned that changes in the existing requirement for sureties on customs bonds could have an impact on the amount of revenue in duties and taxes that flows into the U.S. Treasury.

3. United States Trade Representative (sec. 243 of the bill)

Present law.—Section 141(f)(1) of the Trade Act of 1974 authorized $14,179,000 for the Office of the U.S. Trade Representative in fiscal year 1985, of which not to exceed $80,000 may be used for official entertainment and representation expenses. Current law provides a permanent authorization of appropriations for each fiscal year beginning in fiscal year 1983 for salary increases provided under the Federal Pay Comparability Act of 1970.

Explanation of provisions.—Authorization of appropriations.—Section 243 of the bill amends section 141(f)(1) of the Trade Act of 1974 to provide an authorization of appropriations for fiscal year 1986 of $13,582,000 for USTR. Of this amount, a maximum of $68,000 may be used for official entertainment and representation expenses.

The overall level and limit on official entertainment and representation funds authorized for fiscal year 1986 are the same as current appropriation levels for fiscal year 1985. The authorization level is $597,000 less than the $14,179,000 authorized for fiscal year 1985. The limit on entertainment and representation expenses is $4,000 less than requested and $12,000 less than authorized for fiscal year 1985.

The total authorization requested for fiscal year 1986 of $11,431,000 is $2,151,000 or 16 percent less than current appropriations and somewhat less than the $12 million appropriated for fiscal year 1984. The Committee believes that the funding level requested is inadequate for the USTR to perform its statutory functions as the agency chiefly responsible to the President and the Congress for the development and coordination of U.S. trade policy and for the conduct of trade negotiations. The request assumes the agency will aborb a 5 percent pay cut and 10 percent cut in administrative expenses. No funds are included to cover extra expenses that would result from preparations for a possible new round of multilateral trade negotiations proposed by the President.

In addition, it is expected that a considerable workload will continue for USTR as the lead agency on the Harmonized Commodity Description and Coding System (Harmonized System.) The System is a new international uniform tariff and statistical nomenclature that would replace the Tariff Schedules of the United States if the United States decides to adopt the System and Congress passes the necessary implementing legislation. Technical discussions are in progress with representatives of foreign countries on the changes in U.S. and foreign rates of duty that would result from conversion of current tariff nomenclatures to the new system. Extensive tariff renegotiations with many countries are expected to take place early next year to restore the balance of obligations previously negotiated.

The authorization and appropriation for fiscal year 1985 included an increase from 1984 funding levels of $1.5 million set aside for work on the Harmonized System, including transport and relocation expenses for staff to Geneva, Switzerland, to conduct the tariff renegotiations and for computerized data support, analysis, and interagency coordination. The importance of this activity requires the continued provision of adequate funding support to complete the negotiations and to prepare for possible U.S. implementation.

Employment authority.—Section 243 of the bill also amends section 141(d)(1) of the Trade Act of 1974 to include authority for the U.S. Trade Representative to employ up to 20 individuals at rates of compensation not to exceed the rate of pay for level IV of the Executive Schedule of section 5314 of title 5, United States Code without regard to otherwise applicable civil service employment and compensation laws.

From time to time, the USTR could utilize available expertise in specialized areas and to enhance the staff during the preparations for a new round of multilateral trade negotiations. Such individuals cannot be hired as consultants or contractors because of the nature of their operational responsibilities, such as negotiations, representing the agency at conferences, etc.

Reason for change.—As part of a comprehensive program to raise revenues and reduce the Federal deficit, both the House and Senate budget resolutions contain a proposal to authorize the U.S. Customs Service to assess users fees for processing common carriers, passengers and commercial import arrivals in the United States. The House Budget Resolution, which like the Senate's is based on the Administration's proposed comprehensive fee schedule which would apply to virtually all import transactions, estimates that such fee schedule would result in increased revenues of $473 million in fiscal year 1986, $493 million in FY 1987 and $513 million in FY 1988.

At the hearings held by the Committee on Ways and Means on this subject comprehensive Customs user fee concept was strenously objected to by a number of interested parties. Among the principal objections to the proposal was the allegation that the assessment of a fee on imported merchandise would be inconsistent with the General Agreement on Tariffs and Trade (GATT) and would invite retaliation by our trading partners.

In light of the extremely controversial nature of the comprehensive users fee proposal, particularly as it relates to fees on the entry of imported merchandise, the Committee decided to opt for a more modest proposal. Part 3 of Title II of the bill as reported would assess fees to cover the cost of processing incoming vessels, trucks, trains, private yachts and boats, general aviation aircraft and for the processing of passengers entering the United States by train, air or vessel, but would not assess fees on any commercial entries of imported merchandise. The fee schedule provided for Title II should result in an increase in an annual customs receipts of approximately $200 million with little additional administrative cost to collect the fees and with little disruption on the traveling public.

Explanation of provisions.—Fee structure.—Section 251 of the bill amends section 214 of the Customs Procedural Reform and Simplification Act of 1978 (19 U.S.C. 58a) to provide for the assessment of specified fees to cover the expenses incurred by the Customs Service in processing arrivals at ports of entry in the customs territory of the United States.

Commercial vessels of 100 tons or over would be subject to a fee upon arrival in the United States of $425. Commercial trucks and railroad cars would be assessed a fee upon arrival of $5 per car and private vessels and aircraft would be assessed an annual fee of $25.

Passengers on commercial vessels, aircraft or trains would be subject to a $1 fee upon arrival from Canada, Mexico, a territory or possession of the United States or any island that is an adjacent island within the meaning of section 101(b)(5) of the Immigration

and Nationality Act (8 U.S.C. 1101(b)(5)).[1] Passengers arriving from all other countries would be subject to a fee of $5.00.

The differential in fees for passengers is intended to ease the burden on consumers who travel relatively short distances and consequently pay lower ticket prices because a uniform fee would have a disproportionately adverse impact on them. It is further intended to reflect the fact that higher processing costs are generally associated with Customs' clearance of passengers arriving from more distant locations.

In order to minimize the administrative costs associated with collecting these fees, commercial carriers are directed, in section 251, to collect the fee from the passenger at the time the ticket is purchased; separately identify the fee charged as a Federal inspection fee on the ticket or document issued; and to remit to the Secretary of the Treasury the fees collected under this Act during each calendar quarter before the 31st day after the last day of the quarter.

Except with respect to the services for which fees are imposed under this Act, the Secretary is authorized to continue to charge such fees as may be necessary to cover the costs of providing those services which customs officers were authorized to provide under section 214(a), as in effect before the date of enactment of this Act.

Section 251 further provides that, with regard to the processing of passengers on scheduled airline flights arriving in the United States, no additional charges, such as for overtime for customs officers, may be assessed against the airlines or the passengers other than the fees established by this Act. All other overtime charges would continue to be collected as under current law.

Finally, section 251 provides that the receipts for reimbursable charges, including those collected under this provision, and expenses paid for out of any appropriation for collecting customs revenues that are covered into the Treasury as miscellaneous receipts shall be credited as receipts to a proprietary account in the General Fund of the Treasury. In this way, it is expected that the relationship between the user fees and the services provided by Customs will be clearly reflected in the narrative of the President's budget. User fee collections will not be credited directly to the appropriation as is currently the case for reimburseable charges under section 424 of the Tariff Act of 1930 (19 U.S.C. 1564), but rather deposited into a receipt account with a unique identification code to permit the ready comparison of the amounts collected for commercial services with the amount sought through appropriations to fund those activities.

The Committee urges the Customs Service and the Administration to utilize the increased funds resulting from these fees, to the extent possible, to strengthen the Customs Service's commercial operations, provide better service to the importing community, and more effectively carry out its responsibilities of collecting import duties and protecting U.S. citizens from fraudulent and illegal importations.

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[1] The term "adjacent island" includes Saint Pierre, Miquelon, Cuba, the Dominican Republic, Haiti, Bermuda, the Bahamas, Barbados, Jamaica, the Windward and Leeward Islands, Trinidad, Martinique, and other British, French, and Netherlands territories or possessions in or bordering on the Caribbean Sea.

In this regard, the Customs Service is urged to make best efforts to process incoming airline passengers subject to this fee structure in an expeditious manner. The Committee believes that a reasonable standard to strive for in processing all passengers on arriving flights is an average of 45 minutes.

Conforming amendments.—Section 252 of the bill contains several conforming amendments, including the repeal of section 424 of the Tariff Act of 1930 (19 U.S.C. 1524), which currently provides for receipts for reimbursable charges and expenses to be deposited as a reimbursement to Customs' appropriation instead of being covered into the Treasury as miscellaneous receipts.

Section 252 of H.R. 3034 would further amend section 305(i) of the Rail Passenger Service Act (45 U.S.C. 545(i)) to delete the provision exempting Amtrak for reimbursing the Federal Government for the cost of Customs or Immigration inspection. The change would be consistent with the purpose of the proposed bill, permitting Customs and Immigration to be reimbursed for the costs of services provided Amtrak.

Finally, section 53(e) of the Airport and Airway Development Act of 1970 (49 U.S.C. 1741(e)) is repealed to eliminate the distinction between overtime on Sundays and holidays and that on non-business hours on weekdays for commercial aircraft. However, as provided for in section 251(d), no overtime changes may be assessed for processing arriving airline passengers at any time during the 3-year life of the fee structure provided for in section 251.

Advisory Committee.—Section 253 of the bill provides for the establishment of an advisory committee to meet on a periodic basis and to advise the Secretary on issues relating to performance of Customs' services. The committee is to be made up of representatives from the airline, shipping and other transportations industries, the general public, and others who may be subject to the fees authorized by section 251. It is contemplated that the advice include, but not be limited to, such issues as the time periods during which such services should be performed, the proper number and deployment of inspection officers and the level of fees. The Secretary is directed to give substantial consideration to the views of this Committee in the exercise of his duties.

Effective period for fees.—Section 254 of the bill provides for a delayed effective date of 180 days from the date of enactment to give the Customs Service sufficient time to implement the new fee schedule. The fees provided for in this bill would remain in effect for a 3-year period beginning on that date.

TITLE III—AID TO FAMILIES WITH DEPENDENT CHILDREN AMENDMENTS

A. AFDC Quality Control

Present law.—The Federal government and the States have established ongoing quanlity control systems. These systems have two goals: correcting faults in program administration that contribute to erroneous payments and reducing the extent of misspent benefit dollars. To these ends, they attempt to: (1) measure the extent and dollar value of errors in administration; (2) identify the

types and causes of errors; and (3) specify and monitor corrective actions taken to eliminate or reduce errors.

Fiscal sanctions have also been made a part of these systems. Under these sanctions, States can be held liable for the cost of benefit payments made in excess of Federally established error tolerance levels, often referred to as target error rates. Prior to enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), HHS regulations required States to reach a 4 percent error tolerance level by fiscal year 1983. This policy was known as the Michel amendment and actually required States, between fiscal year 1981 and fiscal year 1983, to make progress toward the 4 percent standard in three equal installments.

P.L. 97-248 reduced the target error rate for AFDC to 3 percent for fiscal year 1984 and thereafter.

Explanation of provision.—The bill would modify the current error rate tolerance level for AFDC and would establish in statute the basic procedures that would be used to collect the error rate data, determine each State's error rate, and collect potential fiscal sanctions. The bill also specifies the basic terms and conditions for granting waivers of the fiscal sanctions. The specific provisions of the legislation are described below.

1. Establish minimum quality control policies and procedures in law.

States would be required to determine the AFDC error rate for each fiscal year in a manner similar to current practice. State could, at their option, collect either 2 six-month samples or an annual sample of their AFDC caseload to develop the error rate but would be prohibited from reducing their sample size.

The Federal re-review, analysis, and notice to the States of the official error rate would have to occur within six months after the close of the fiscal year for which the data are collected or six months from the date a completed State sample is submitted to the Federal regional office, whichever is later.

After completing the data collection process: (1) States would be required to develop and submit to the HHS Secretary a corrective action plan for reducing the indentified errors (including those not subject to fiscal penalties as discussed below); (2) the HHS Secretary would review and approve the plan, and; (3) States would be required to implement the corrective actions. The HHS Secretary would be required to establish a timetable for these activities in regulations and monitor the corrective action process. States with adjusted State error rates that are consistently at or below the adjusted State tolerance level (without excluding technical errors) would not be required to submit a corrective action plan for the Secretary's approval.

2. Set a new national standard for the AFDC error rate of 3.5 percent.

The standard tolerance level for overpayment errors would be permanently set a 3.5 percent. Under current law, States must reach a 4 percent standard tolerance level by fiscal year 1983; this declines to 3 percent for fiscal year 1984 and thereafter.

3. Determine the adjusted State error rate.

The procedures described in item 1 above would be used to obtain the raw error rate data. Subsequently, two adjustments would be made to produce the adjusted State error rate.

First, technical errors would be excluded for fiscal sanctions purposes. these are paperwork ommissions which would not change the AFDC payment level. They include: failure to provide evidence in the case record of social security numbers, assignment of rights to support, cooperation in obtaining support, WIN registration, and other errors which have no fiscal impact.

Second, the point estimate of a State's error rate would be the lower bound of the range within which a State's true error rates falls, rather than the midpoint, if the State has a sample size sufficent to produce a lower limit of 2.5 percentage points or less than the midpoint. In the calculation of the lower confidence level, the Secretary would have the authority to promulgate regulations to adjust for variability among States in the number, proportion or dollar value of cases where the findings of the State quality control review differ from the Federal findings. These regulations would assure that States could not arbitrarily manipulate the original State findings to maximize the benefit of using the lower bound. It is expected that the regulations will establish an objective standard for the adjustment, most probably using a mathematical formula to be developed.

4. Recognize that certain factors beyond a State's control influence the error rate by adjusting the standard tolerance level annually for each State.

The current quality control system does not recognize error-relevant socioeconomic, geographic and program differences among the States which contribute to higher error rates and are not fully within the control of the States. Studies have shown that it is more difficult to make a correct determination of eligibility and payment amount in some cases than in others. For example, a case in which a member of the family is working, or has a recent work history, is more complicated than one in which there is no potential source of outside income. Similarly, an agency in a heavily populated area is likely to have a higher volume of cases which can contribute to the error rate.

To account for these factors, the standard tolerance level of 3.5 percent would be adjusted as follows:

(a) Add 0.5 percent to the standard level if the State has operated an AFDC unemployed parent program during the fiscal year.

(b) Add 0.1 percent to the standard level, up to a maximum of 0.5 percent, for each 20 percent increment by which the State exceeds the national average in terms of percent of total State AFDC caseload with earnings.

(c) Add 0.1 percent to the standard level, up to a maximum of 0.5 percent, for each 20 percent increment by which the State exceeds the national average in terms or population density (population per square mile of land area).

The steps described in item 3 produce the adjusted State error rate. The steps described in item 4 produce the adjusted State tolerance level.

5. Impose fiscal sanctions on the basis of the adjusted State error rate and the adjusted State tolerance level.

A State's fiscal sanction would be equal to the Federal portion of benefits paid above the adjusted State tolerance level using the adjusted State error rate.

A sanction amount would be reduced by the Federal share of overpayments collected by the State in the fiscal year to which the error rate applies.

The current authority for the HHS Secretary to waive sanctions to acknowlege certain circumstances would be retained and expanded. States could request a waiver based on the State's good faith effort to reduce errors. In making the waiver request, States would also be permitted to challenge the Federal error rate findings. The HHS Secretary would review and act on the request according to a timetable specified in regulations.

The regulations would also specify the criteria that would be used in assessing waiver requests and the relative importance of each factor so that States may informally assess whether a waiver request is appropriate. In reviewing the waiver request, the HHS Secretary would be required to consider the following:

(a) *Factors beyond the State's control*—such as disasters (fire, flood or civil disorders); strikes by State or other staff needed to determine eligibility or process changes in cases; sudden workload changes resulting from changes in Federal or State law and regulations or rapid caseload growth; and State actions which were the result of incorrect policy interpretations by a Federal official.

(b) *Factors related to agency commitment*—such as demonstrated commitment by top management to the error reduction program; sufficiency and quality of operational systems which are designed to reduce errors; use of effective systems and procedures for the statistical and program analysis of quality control and related data; and effective management and execution of the corrective action process.

(c) *Other factors as appropriate*—these may be identified by the Secretary in regulations or may be detailed by States in their waiver requests but would include past State error rate performance as well as the cost effectiveness of error reduction efforts.

States would be permitted to appeal the Secretary's decision on the waiver request described above to the HHS Grant Appeals Board and could also appeal to the courts.

In lieu of the waiver authority identified above, the Secretary would be required to permanently waive a sanction if the State submits a plan for the reduction of errors which includes the expenditure of additional State administrative funds equal to one-half of the sanction amount. These expenditures would be a Federally-matched administrative expense.

Effective date.—For FY 81 and 82, States would have the option of applying current law (the Michel amendment) or the new qual-

ity control system and standards. For FY 83 and thereafter, the new quality control system and standards would apply.

B. Teenage Pregnancy Block Grant

Present law.—Although some States are operating pilot service programs for teenage families, comprehensive prevention and service programs targeted to AFDC recipients do not exist in each State.

Explanation of provision.—

The bill authorizes a two-year grant program to permit the State AFDC agency to operate a two-part teenage pregnancy program.

Prevention program for AFDC families.—These activities would be targeted to male and female children in AFDC families and would include active parent participation; parental consent would not be required. The program would address several factors which have been shown to play important roles in determining teenage sexual activity and contraceptive use. These include low self-esteem and aspirations, ignorance about pregnancy and contraception, fear or embarrassment about contraceptive use, and concern about the effect of sexual abstinence or contraceptive use on the relationship.

Children would be encouraged to develop believable education and employment goals for the future and States would combine new and existing resources to assist them to achieve those goals. Such programs would encourage children to postpone sexual activity and child bearing in order to achieve these goals; taking responsibility for family planning would also be stressed.

Comprehensive service program for teenage AFDC parents.—Participation would be voluntary; male and female teenage parents who elect to participate would be required to seek a high school degree (or equivalent) and would receive services, including training, day care and transportation, to help them become self-sufficient and avoid long-term welfare dependence. States would be permitted to request a waiver to require participation in the program in jurisdications with sufficient funding to serve all of those who would be eligible to participate.

These activities would be financed through a block grant to each State. The legislation authorizes the appropriation of $50 million in fiscal year 1986 and $100 million in fiscal year 1987. States would be entitled to receive a grant in each of the two fiscal years for which the program is authorized. Funds could only be used for the purposes specified above.

These funds could be used only for AFDC eligible individuals. However, it is expected that State prevention and service programs may also serve non-AFDC eligible individuals so long as these grant funds are not used to provide services to the non-AFDC population. In addition, in each locality within a State, both a prevention and a service program must be offered. However, it is not the intention of this legislation to duplicative in any way programs that may already be available within a jurisdiction. For this reason, States may use these funds to set up a prevention program, a service program or both, so long as prevention and service activities are available in each site receiving the block grant funds.

The appropriation would be allocated to the States on the basis of their percentage share of national AFDC benefit expenditures. States would be required to target the funds to areas of the State with a high rate of teenage pregnancy and/or a high incidence of infant mortality. Funds not used by any State would be reallocated on the basis of need to other States.

These block grants funds are in addition to AFDC funds provided to the States and are to supplement and not replace any funds that may be available for the same general purpose. Specifically, the funds may not be used to provide services which are available under the Medicaid program.

The legislation includes a prohibition on the use of block grant funds for the performance of abortions and for the counseling of individuals to have abortions except where the life of the mother would be endangered if the fetus were carried to term. This prohibition applies solely to the use of funds provided under the teenage pregnancy block grant established by section 302 of this bill, and is not intended in any way to alter current practices or law and regulations of other title IV or any other Social Security Act programs or other Federally funded health and public assistance programs.

The monies would flow to the State upon submission of a plan in accordance with regulations published by the Secretary of HHS. The plan would have to be approved by the Secretary; the monies could only be used for AFDC eligible individuals, and could not replace funds otherwise allocated for this purpose. A thorough evaluation would be required by July 1, 1987.

Effective date.—The teenage pregnancy prevention and services block grant would be in effect only from October 1, 1985 until September 30, 1987. However, funds allocated to States before September 30, 1987, could be carried over to the subsequent fiscal year as provided in the legislation.

C. AFDC For Unemployed Two-Parent Families

Present law.—It is a State option to aid needy two-parent families in which the principal earner is unemployed (i.e, the principal earner is working less than 100 hours per month and has six or more quarters of work in any 13-calendar quarter period ending within one year prior to applying for AFDC). Twenty-three States, Guam and the District of Columbia provide this assistance to needy intact families. In the States without a two-parent program, intact families cannot receive assistance or must separate in order to qualify for AFDC.

The States currently *without* a two-parent AFDC program are the following: Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Maine, Mississippi, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming.

Explanation of provision. —Effective October 1, 1986, the bill mandates that the current AFDC program for unemployed parents be implemented in all States. As a result, all States would aid needy two-parent families in which the principal earner is unemployed.

In addition, the definition of "quarters of work" would be modified to permit, at State option, the substitution of participation in school or training as follows: (1) school attendance would be limited to elementary or secondary school; (2) four quarters of vocational training could be substituted for four quarters of work; (3) attendance in school or vocational training would have to have been full-time; and (4) at least two of the six quarters must be quarters of work.

Effective date.—The provision would be effective on October 1, 1986.

TITLE IV—RAILROAD UNEMPLOYMENT REPAYMENT TAX AND UNEMPLOYMENT COMPENSATION AMENDMENTS

1. Railroad Unemployment Compensation

Present law.—The authority for the railroad unemployment compensation system to borrow from the railroad retirement account expires on September 30, 1985. On that date, the outstanding debt to the retirement account is estimated to be $783 million, of which $526 million is principal and $257 million is accumulated interest.

There has been no automatic mechanism in the law to repay loans from the retirement account as they occur. Loans are repaid out of basic contributions to the unemployment account when the Railroad Retirement Board determines that there are sufficient funds in the unemployment account to make a repayment.

The Railroad Retirement Solvency Act of 1983 established a repayment tax that will begin on July 1, 1986 and will expire on September 30, 1990. The tax rate will begin at 2.0 percent and increase by 0.3 percent a year. The tax is paid on the first $7,000 in wages paid to a rail employee.

Explanation of provision.—(1) The loan repayment tax, scheduled to begin on July 1, 1986 at a 2% rate with increases of .3% a year, is amended as follows:

Calendar Year	1986	1987	1988	1989	1990
Current law	2.0	2.3	2.6	2.9	3.2
Tax rate: Committee bill	4.3	4.7	6.0	2.9	3.2

(2) The RRUI Account's authority to borrow from the Railroad Retirement Account is extended, effective October 1, 1985.

(3) An automatic surcharge of 3.5% on an annual wage base of $7,000 will be levied if the RUI Account has to borrow from the retirement account. The surcharge will be used to repay such loans.

Effective date.—The provision would be effective October 1, 1985.

2. Federal Supplemental Compensation

Present law.—The Federal Supplemental Compensation program (FSC), which provided additional weeks of unemployment compensation to individuals who had exhausted their regular State benefits, was due to expire on April 6, 1985. Public Law 99-15, enacted on April 4, 1985, allowed individuals who were receiving FSC benefits for the week of March 31—April 6, to continue to receive the

remainder of their benefits. No new FSC benefits were payable after April 6, 1985. Under P.L. 99-15, the remaining weeks of FSC benefits had to be collected in consecutive weeks of unemployment. Any interruption of benefits, for whatever reason, ended an individual's eligibility for FSC benefits.

Explanation of provision.—The Committee bill allows certain unemployed individuals in the State of Pennsylvania to collect the remainder of their FSC benefits, notwithstanding the requirement in P.L. 99-15 that such benefits be collected in consecutive weeks. These individuals were receiving FSC for the week of March 31, 1985—April 6, 1985, and were eligible to collect the remainder of their benefits under P.L. 99-15. The collection of their remaining benefits was interrupted, however, when they were called up in the National Guard in early June to provide services during a major disaster in the State declared by the President to warrant assistance by the Federal government under the Disaster Relief Act of 1974. This service in the National Guard, which lasted for a week for most of the affected individuals, cut them off from the remainder of their FSC benefits. The provision would allow these individuals to collect the remainder of their benefits.

The provision applies only to individuals who were called up for National Guard duty by the Governor in a disaster declared by the President on June 3. It applies to weeks of unemployment occurring after the individual had completed his Guard duty but during which he may not have met the work search or availability requirements of State law because he failed to file claims believing he was no longer eligible (having failed to file in consecutive weeks). It is intended to apply only until an individual's FSC benefits are exhausted or he becomes employed, whichever occurs earlier.

Effective date.—The provision would be effective for weeks of unemployment beginning after March 31, 1985.

TITLE V—REVENUE AMENDMENTS

1. Internal Revenue Service Budget for Fiscal Year 1986 (sec. 501 of the bill)

Present law.—The Internal Revenue Service (IRS) is responsible for administering and enforcing tax laws. More than 95 percent of total Federal budget receipts are derived from the tax laws as administered by the IRS.

For fiscal year 1986, the Administration proposed 86,489 staff positions for the IRS and a total budget of $3.5 billion. This was a decrease of 1,254 staff positions and $30.4 million from the fiscal year 1985 appropriation (including requested amounts).

Reasons for change.—The Committee is concerned that the Administration's budget proposal would not provide sufficient resources for the IRS to accomplish this vital role in raising Federal revenues. The Appropriations Committee has approved (in H.R. 3036; H. Rep. No. 99-210, July 18, 1985) an increase of $178 million over the Adminstration's proposal for fiscal year 1986.

Explanation of provisions.—The Committee on Ways and Means endorses the recommendation of the Appropriations Committee (in H.R. 3036). Consequently, the bill includes a sense of the Congress

resolution endorsing this recommendation. That recommendation restores the Administration's proposed reductions in the fiscal year 1986 IRS budget and provides for an inc ease beyond that level. The Committee understands that these funds will be used to increase computer capacity and to hire new employees, who primarily would process tax returns and taxpayer correspondence. This restoration and increase are necessary for efficient tax administration and collection of taxes owed to the Government. This increase in IRS collection effort will increase budget receipts.

Revenue effect.—This provision is estimated to increase fiscal year budget receipts by $228 million in 1986, $465 million in 1987, $580 million in 1988, $640 million in 1989, and $708 million in 1990.

2. Extension of Cigarette Excise Tax Rates and Establishment of Tobacco Equalization Trust Fund (sec. 502 of the bill and sec. 5701 and new sec. 9505 of the Code)

Present law.—Cigarette excise tax: An excise tax is imposed on cigarettes manufactured in or imported into the United States (Code sec. 5701). The present tax rate on small cigarettes is $8 per thousand (i.e., 16 cents per pack of 20 cigarettes). The tax rate on large cigarettes generally is $16.80 per thousand; proportionately higher rates apply to large cigarettes that exceed 6.5 inches in length. Small cigarettes are cigarettes weighing no more than 3 pounds per thousand. Most taxable cigarettes are small cigarettes.

The present cigarette excise tax rates are scheduled to decrease by one-half on October 1, 1985 (e.g., to 8 cents per pack of 20 for small cigarettes). Under present law, revenues raised by the cigarette excise tax are deposited in the general fund of the Treasury.

Tobacco price support program: The Federal Government conducts a price support program for tobacco produced in the United States. The general structure of this program is similar to programs conducted by the Government with respect to other agricultural commodities. The Commodity Credit Corporation (CCC) administers the program through loans to 13 tobacco producer cooperatives. Under the tobacco price support program, the Secretary of Agriculture annually establishes a target price for each type of tobacco eligible for price support. The 13 producer cooperatives in turn make nonrecourse loans to tobacco farmers with respect to tobacco not purchased at market by private parties; the unsold tobacco is pledged as collateral for repayment of the loans.[1]

The amounts of the loans to tobacco farmers are based on the established price support target prices. The 13 producer cooperatives market the tobacco taken as loan collateral by them and repay the CCC loans. As a result of the nonrecourse nature of the loans to growers, the risk of net losses on the disposition of tobacco forfeited to the cooperatives (i.e., the difference between the established target price and the ultimate market price plus interest and carrying costs) is transferred from the tobacco growers to the producer cooperatives.

Since 1981, the tobacco price support program has been conducted on a "no net cost" basis. Under the No Net Cost Tobacco Pro-

[1] Code section 77 permits taxpayers to treat receipt of CCC loans as sales for Federal income tax purposes of the commodities that are pledged as collateral.

gram, tobacco producers rather than the Federal Government underwrite costs of the tobacco price support program. In addition to establishing a price support target price as discussed above, the Secretary of Agriculture annually establishes a grower fee with respect to each type of tobacco eligible for price support. This fee is paid by growers with respect to each pound of tobacco sold or pledged as collateral for a loan from one of the 13 tobacco producer cooperatives. The fees are deposited in special no net cost funds maintained by each of the 13 producer cooperatives. Monies in these funds are used to offset any net losses realized on the disposition of tobacco forfeited to the cooperatives by growers.

Reasons for change.—Cigarette excise tax: The Committee believes that the present cigarette excise tax rates should be extended, without a new sunset date, for two reasons. First the Committee believes that the present budgetary situation requires continuation for an indefinite period of the revenues produced as a result of the present tax rates. The Committee believes that, to the extent possible, continuation of existing tax rates is preferable to adoption of additional, new revenue measures to satisfy budgetary requirements.

Second, when Congress increased the cigarette excise tax rates to their present levels in 1982, the increases was the first such action since 1951. The Committee believes that the present tax rates are not an undue burden on the tobacco industry. Because the cigarette tax is imposed at flat, set amounts for each of the two types of taxable cigarettes, effective tax rates have declined with inflation, and even after the 1982 increases, the effective rate of tax imposed on cigarettes remain today than the effective rates in 1951.

Tobacco price support program: The Committee was informed that losses experienced by the 13 tobacco producer cooperatives in recent years have increased substantially. In light of these increases, the Committee was told that, if the grower fees presently used to underwriter costs of the price support program continued to be the sole source of funding, the fees would have to be increased to a level that could impose an undue burden on tobacco producers. The Committee determined, therefore, that dedication for a temporary period of a limited amount of the revenues derived from extention of the present cigarette excise tax rates will assist the tobacco growers in funding the no net cost program. The Committee believes that the creation of a separate Tobacco Equalization Trust Fund in the Treasury is the appropriate method of managing the excise tax revenues dedicated to the tobacco price support program. The Committee understands that the revenues in the Trust Fund will be used to supplement grower or other fees that will continue to be assessed under the no net cost program.

Explanation of provision.—Cigarette excise tax: The bill makes permanent the present cigarette excise tax rates. Thus, small cigarettes will continue to be taxed at the rate of 16 cents per pack of 20 cigarettes.

Tobacco price support program: The bill appropriate a portion of the extended cigarette excise tax into a newly established Tobacco Equalization Trust Fund to supplement the funding provided by grower or other fees for the tobacco price support program. The Trust Fund will be administered by the Secretary of the Treasury.

An amount equal to $.50 per thousand cigarettes (one cent per pack of 20 cigarettes) of the cigarette excise tax on small cigarettes is appropriated to the Trust Fund. A corresponding portion of the tax on large cigarettes also is dedicated to the Trust Fund. These revenues will be transferred to the Trust Fund from excise tax revenues received during the period October 1, 1985, through September 30, 1990.

The Secretary of the Treasury is authorized, pursuant to appropriation Acts, to use amounts in the Trust Fund to offset net losses realized by CCC on price support loans made to the 13 tobacco producer cooperatives with respect to tobacco produced in crop years after 1981. The Committee understands that legislation to be recommended by the Committee on Agriculture will provide rules ensuring that all 13 of the producer cooperatives participating in the tobacco price support program benefit ratably according to their overall net losses on price-suppported tobacco from each crop year after 1981.

Effective dates.—Cigarette excise tax : The extension of the cigarette excise tax rates applies to cigaretts removed from bonded premises after September 30, 1985.

Tobacco price support program.—The provisions creating the Tobacco Equalization Trust Fund are effective on October 1, 1985. The appropriation of excise tax revenues to the Trust Fund applies to such revenues received in the Treasury after September 30, 1985, and before October 1, 1990.

Revenue effect.—The extension of the present-law cigarette excise tax rates is estimated to increase net fiscal year budget receipts by $1,536 million in 1986; $1,682 million in 1987; $1,686 million in 1988; $1,700 million in 1989; and $1,705 million in 1990.

3. Increase in Coal Excise Tax for Black Lung Disability Trust Fund (sec. 503 of the bill and sec. 4121 of the Code)

Present law.—A manufacturers excise tax is imposed on domestically mined coal (other than lignite) that is sold or used by the producer of the coal (Code secs. 4121, 4218). Under present law, the rate of tax is the *lesser* of (1) $1 per ton for coal from underground mines and 50 cents per ton for coal from surface mines, or (2) four percent of the price for which the coal is sold.[2]

Amounts equal to the revenues collected from the coal excise tax are automatically appropriated to the Black Lung Disability Trust Fund (the "Trust Fund"). The Trust Fund pays black lung disability benefits, under claims filed after 1973, to coal miners (or their survivors) who have been totally disabled by black lung disease in cases where no coal mine operator is found responsible for the individual miner's disease.

Reasons for change.—At the end of fiscal year 1984, the Trust Fund had a cumulative deficit of approximately $2.5 billion; this amount represents advances from the general revenues which are repayable with interest. The Department of Labor estimates that,

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[2] Under present law, the tax rates are scheduled to be reduced by 50 percent on the earlier of January 1, 1996, or any January 1 after 1981 on which there is no balance of repayable advances to the Trust Fund for general revenues and no unpaid interest on such advances.

unless the present rates of the coal excise tax are increased, this deficit could reach $30 billion by 2010.

In order to reduce and eventually eliminate this deficit, and thereby restore fiscal solvency to the Trust Fund, the Committee agreed to increase the coal excise tax, as shown in the table below. Beginning two years after complete retirement of Trust Fund indebtedness, the tax will reverts to the 1985 levels. The committee was informed that the Department of Labor (DOL) estimates that these tax rate increases, coupled with the effect of a DOL proposal for a temporary cap on black lung benefits payments, would make further borrowing from general revenues unnecessary by the end of fiscal year 1989 and make possible total retirement of all Trust Fund accumulated indebtedness by the end of the century.

Explanation of provision.—The provisions increases the per-ton coal excise tax rate (including the sales price ceiling), beginning January 1, 1986, as shown in the following table:

Calendar year(s)	Tax on underground coal	Tax on surface coal	Ceiling (percent of sales price)
1986–90	$1.50	$0.75	6.0
1091–95	1.60	0.80	6.4
1996–	1.50	0.75	6.0

In lieu of the rates shown in the above table for 1996 and later years, the 1985 rates ($1 or 50 cents per ton; four percent ceiling) will be reinstated for any calendar year after 1995 if throughout the two most recent fiscal years ending before the beginning of such calendar year there was no balance of repayable advances made to the Trust Fund, and no unpaid interest on such advances.

Effective date.—The provision applies to sales of taxable coal after December 31, 1985.

Revenue effect.—The provision is estimated to increase net fiscal year budget receipts by $213 million in 1986, $229 million in 1987, $236 million in 1988, $246 million in 1989, and $256 million in 1990.

4. Tax Treatment of Railroad Retirement Benefits (sec. 504 of the bill and sec. 86(d) of the Code

Present law.—Under present law, a portion of Railroad Retirement system benefits computed by using the social security benefit formula (tier 1 benefits) are subject to Federal income tax for taxpayers whose incomes exceed certain levels (generally, $25,000 for unmarried individuals and $32,000 for married individuals filing a joint return). These benefits may be available at an earlier age under the Railroad Retirement system than under the social security system. Other benefits under the Railroad Retirement system are subject to Federal income tax for all recipients to the extent the payments exceed the amount of the individual's previously taxed contributions to the plan.

Reasons for change.—In 1983, when tier 1 Railroad Retirement benefits were made subject to taxation in the same manner as social security benefits, the purpose of taxing such benefits was to improve tax equity by treating more nearly equally all forms of re-

tirement and other income that are designed to replace lost wages. Congress articulated its belief at the time that tier 1 Railroad Retirement benefits, because they are essentially equivalent to social security benefits, should not be fully taxable.

The Committee believes that tier 1 Railroad Retirement benefits should be taxed in the same manner as social security benefits only to the extent that they are equivalent to what the individual would have received if the individual's employment under the Railroad Retirement system had been covered employment for social security purposes. The Committee concludes that the portion of tier 1 Railroad Retirement benefits that is not equivalent to a social security benefit (and, therefore, is essentially the same as a private pension benefit) should not be eligible for the special tax treatment accorded social security benefits.

Explanation of provision.—Under the bill, a portion of tier 1 Railroad Retirement benefits, equal to the amount of the annuity under the Railroad Retirement Act of 1974 that equals the social security benefits to which the individual would have been entitled if all of the individual's employment on which the annuity is based had been employment for social security benefit purposes, continues to be taxed in the same manner as social security benefits. In addition, a minimum monthly annuity benefit (described in sec. 3(f)(3) of the Railroad Retirement Act of 1974) will be taxed in the same manner as social security benefits. Other tier 1 Railroad Retirement benefits will be taxed under the rules that apply to all other payments under the Railroad Retirement system.

Thus, Railroad Retirement disability benefits that are payable to individuals who would not be entitled to social security disability benefits or in excess of the social security disability benefits to which an individual would be entitled generally will be fully taxable. Similarly, Railroad Retirement benefits that are payable at an age earlier than social security benefits or in an amount greater than social security benefits will be fully taxable.

Effective date.—The provision is effective for monthly benefits for which the generally applicable payment date is after December 31, 1985.

Revenue effect.—The provision will increase fiscal year budget receipts by $34 million in 1986, $62 million in 1987, $65 million in 1988, $65 million in 1989, and $63 million in 1990.

5. Pension Benefit Guaranty Corporation Premiums

Present law.—The Employee Retirement Income Security Act of 1974 (ERISA) established a program of insurance for employee benefits under most tax-qualified, private, domestic, defined benefit pension plans.[3] The insurance program is administered by the Pension Benefit Guaranty Corporation (PBGC), a Federal corporation within the Department of Labor. The Board of Directors of the PBGC consists of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Commerce. The Secretary of Labor is

[3] A defined benefit pension plan provides a specified level of benefits for participants. A church pension plan is generally exempt from the insurance program unless the plan has elected to be subject to ERISA standards. Exclusions are also provided for plans of small professional service employers and certain other employers.

the Chairman of the Board. Receipts and disbursements of the PBGC are included in the budget of the United States.

Under present law, a defined benefit pension plan that is subject to the insurance program is required to pay annual premiums to the Pension Benefit Guaranty Corporation (PBGC). The PBGC is required by ERISA to maintain four separate premium rate and base schedules under the program. Under the Act, the PBGC maintains separate schedules for basic and nonbasic benefits under single-employer plans and corresponding schedules for multiemployer plans.[4] Insurance of basic benefits under a plan is mandatory.

Basic benefits under a single-employer plan (generally consisting of nonforfeitable retirement benefits) are insured by the PBGC up to the lesser of $750 per month, adjusted for inflation since 1974 ($1,687.50 for 1985) or a participant's average monthly compensation for the period of 5 years for which that compensation is the highest. The insurance of benefits is generally phased in over a 5-year period.

ERISA provides that the annual per-participant premium for insurance of basic benefits under a single-employer plan is $2.60.[5] The annual per-participant premium for insurance of basic benefits under a multiemployer plan is $1.80 for plan years beginning in 1985 or 1986, $2.20 for plan years beginning in 1987 or 1988, and $2.60 for plan years beginning thereafter. Special rules are provided for cases in which an employee participates in more than one single-employer plan maintained by the same employer. Similar rules apply to employees with multiple coverage under multiemployer plans. Generally, the level of benefits guaranteed by the PBGC is lower under a multiemployer plan than under a single-employer plan.

The PBGC is authorized by ERISA to revise the premium rate and base schedules for basic benefits under single-employer plans and multiemployer plans whenever it determines that revision is necessary. Approval by the Congress is required, however, for per-participant annual premiums in excess of $2.60. A proposed change in a schedule is to be submitted to the Committee on Ways and Means and the Committee on Education and Labor of the House of Representatives and to the Committee on Finance and the Committee on Labor and Human Resources of the Senate. ERISA requires that premium rates prescribed by the PBGC must be uniform for all single-employer plans with respect to basic benefits. The PBGC is authorized by ERISA to provide a risk-related premium (within limits) for single-employer and multiemployer plans, but this authority has not been exercised.

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[4] Under ERISA, a plan is a multiemployer plan if (1) more than one employer is required to make plan contributions, (2) the plan is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and (3) the plan meets such other requirements as the Secretary of Labor may prescribe by regulations. In determining whether a plan is a multiemployer plan, employers under common control are treated as one employer. Special rules are provided for terminated plans and for transition cases (Code sec. 414(f) and ERISA sec. 4001(a)(3)). A single-employer plan is a pension plan that is not a multiemployer plan.

[5] The annual, per-participant premium for single-employer plans was initially set by ERISA at $1.00. That premium was increased by Public Law 95-214 to $2.60, effective for plan years beginning after December 31, 1977. Public Law 96-364 increased premiums for multiemployer plans from $.50 to the levels presently provided.

The PBGC maintains a trust fund and a revolving fund for insurance of benefits under terminated plans. Separate funds are maintained for single-employer plans and multiemployer plans. The funds maintained by the PBGC to provide benefits under terminated single-employer plans are the sole Federal source of guaranteed benefits for single-employer plans. The funds maintained by the PBGC to provide guaranteed benefits under multiemployer plans are the sole Federal source of guaranteed benefits for those plans. The PBGC is authorized to borrow up to $100 million from the Treasury of the United States.

Reasons for change.—The Budget Message of the President for fiscal year 1986 indicated that, under present law, the deficit of the Pension Benefit Guaranty Corporation is expected to increase. According to the Message, the budget reflects the Administration's request that the Congress approve an increase in the single-employer premium to a level sufficient to cover projected claims, and amortize the current deficit over a reasonable period of time. The Message indicates that the Administration also supports "legislation to revise the insurance program for single-employer plans in order to close loopholes in the Employee Retirement Income Security Act of 1974 that allow unwarranted assignment to the Corporation of liabilities for unfunded benefits".

The PBGC presently estimates that its deficit will be $679 million at the end of the 1986 fiscal year.[6] The PBGC estimates that the deficit in its single-employer program will be $721 million at that time.

The Board of Directors of the PBGC has requested that the annual, per-participant premium for single-employer plans be increased to $7.50 from $2.60, effective for plan years beginning on or after January 1, 1985. In a letter of April 9, 1985, addressed to the Chairman of the Committee on Ways and Means, the Acting Executive Director of the PBGC stated on behalf of the Board of Directors that:

> Our current request for a $7.50 premium reflects the need to fund properly existing liabilities of approximately $1.6 billion and future losses, expected to average $185 million per year, over the next 15 years. The immediate need for the increase is now even more apparent than it was in the last session of the Congress. Sometime early in FY '85, PBGC's cash flow, as reflected in the Federal Budget accounts, turned negative, and PBGC for the first time began adding to the size of the Federal deficit. Such a trend would accelerate alarmingly in succeeding years should an increase not be adopted.

The PBGC has indicated that an annual per-participant premium of $8.10, effective for plan years beginning after December 31, 1985, is approximately equivalent to a premium of $7.50 effective for plan years beginning after December 31, 1984.

After considering the request of the Administration, the Committee determined that the premium for single-employer plans should be increased to $8.00 for plan years beginning after December 31,

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[6] The Budget Message of the President estimated that the deficit of the PBGC would be $853 million at the end of the 1986 fiscal year. This projection has been revised in light of more complete information with respect to the 1984 fiscal year.

1985. The premium increase was made prospective because of the administrative burdens that would be imposed on plans if a retroactive increase were adopted and because the PBGC has indicated that this brief deferral will not jeopardize benefits under the program.

Because of present uncertainty as to the need for a structural revision of the program and the need to curtail abuses, the Committee agreed to limit the increased premium to a 3-year period. The Committee expects that, during this period, the PBGC and others will work with the relevant committees on recommendations with respect to benefits subject to insurance under the program, the means of financing of that insurance, and the need for additional measures to prevent abuse. Accordingly, under the Committee's bill, the annual single-employer plan per-participant premium returns to $2.60 for plan years beginning after December 31, 1988.

Explanation of provision.—Under the bill, the annual per-participant premium for single-employer plans is increased to $8.00, effective for plan years beginning after December 31, 1985, and before January 1, 1989. Under the bill, the premium for plan years beginning after December 31, 1988, is $2.60. The bill does not modify the premiums for multiemployer plans.

Budget effect.—This provision is estimated to reduce fiscal year budget outlays by $161 million in 1986, $212 million in 1987, and reductions in budget outlays for budget purposes.)

III. Other Matters To Be Discussed Under House Rule

A. Vote of the Committee

In compliance with subdivision (B) of clause 2(l)(2) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the Committee on the motion to report H.R. 3128:

H.R. 3128 was ordered favorably reported by a vote of 22 to 13.

B. Oversight Findings

In compliance with subdivision (A) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the following statement is made with respect to the Committee's oversight findings:

The provisions of H.R. 3128 are consistent with the oversight findings of the Committee on Ways and Means and its subcommittees, as indicated by the information below and the explanations of the provisions in a previous section of this report.

Section 101 of the bill, which would provide for a rate of increase in payments for inpatient hospital services, is consistent with the General Accounting Office report on the use of unaudited cost reports. In its report the GAO determined that the use of unaudited 1981 cost reports by the Secretary in developing the PPS rates overstated the actual costs incurred by the hospitals in the base year by 4.39%. In addition, the Prospective Payment Commission (ProPAC), in its April 1, 1985 report to the Secretary of HHS, recommended an update of 2.8% for PPS hospitals. Futhermore, ProPAC recommended that PPS-exempt hospitals also receive an update for FY 1986.

Section 104 of the bill, which would change the formula for the indirect teaching adjustment, is consistent with the findings of the Congressional Budget Office. According to CBO the current linear method of calculating the adjustment factor may over compensate those hospitals with the highest interns to residents bed ratios. CBO suggested that an adjustment made on a variable basis would more accurately reflect the non-linear cost relationship. Futher, Pro PAC recommended that interns and residents assigned to the outpatient department be included in determining this adjustment. This recommendation was included in the provision.

Section 147 of the bill, which would change the payment policy for assistants at surgery for certain cataract operations and other operations, is based upon findings of the Office of the Inspector General of HHS in its OIG Audit Report (ACN 01-52001). The OIG, in its review of medicare payment for assistant surgeon services during cataract surgery, found that their services were not medically necessary in most situations. This finding was predicated on the practices of many primary opthalmic surgeons who do not use them and the restrictive coverage policies of medicare carriers in nine states. The recommendations of the OIG were incorporated into this section.

Section 148 of the bill, which would place a limitation on medicare payment for cataract surgery patients, is based on findings by the General Accounting Office. In its report, 'Opportunities to Reduce Medicare Payments for Prosthetic Lenses While Enhancing Nationwide Uniformity of Benefits', (GAO/HRD 85-25), the GAO recommended that better controls be established regarding the replacement of prosthetic lenses (i.e. cataract contacts and eyeglasses) and the related professional services. The recommendations of GAO were included in this section.

In addition, the Subcommittee or Health took testimony from the Administrator of the Health Care Financing Administration, GAO, OIG, physician, hospital, supplier, beneficiary and other organizations. Several of their recommendations are included in H.R. 3128.

Section 302, which would provide grants for programs to assist pregnant individuals and teenage parents in achieving self-sufficiency, is based upon oversight hearings of the Subcommittee on Public Assistance and Unemployment Compensation. In these hearings, the Subcommittee learned that teenage mothers are frequently the children of teenage parents. Often they do not finish high school. They usually do not receive child support from the baby's father and over time they generally have more children than non-teenage mothers. Today, most teenage mothers do not marry the father of their child, but if they do, the marriage often ends in divorce. Most end up as single parents earning low wages, if they are able to find work at all.

Without an education or job skills, teenage mothers must frequently turn to aid to families with dependent children (AFDC) for meeting their needs. In fact, studies show that half of all AFDC expenditures go to households in which the mother had her first child as a teenager. Approximately 60 percent of all teenage mothers receive welfare at some time and among AFDC mothers under the age of 30, fully 61 percent were teenage mothers.

Section 303, which mandates aid to families with dependent children in two-parent families in all states, is based upon studies and hearings of the Subcommittees on Oversight and Public Assistance and Unemployment Compensation.

In May, the Congressional Research Service and the Congressional Budget Office reported the results of a study, requested by Subcommittees. The study found that there were 13.8 million poor children in 1983 and that the incidence of poverty among children climbed more than 50 percent from 1973 to 1983. Children are the poorest age group of the entire population. More than half the children in all female-headed families are poor while more than two-thirds of the children in black female-headed families are poor. In excess of 2.5 million children were poor in 1983 even though a parent worked full-time year round. Almost half of all black children and more than one-third of all hispanic children were poor in 1983.

Whether poverty is measured before or after government transfer payments (social insurance and welfare) and whether the income counted includes or excludes noncash benefits and money paid as taxes, child poverty rates rose especially sharply from 1979 to 1983.

Section 501, which restores funding for the Internal Revenue Service, is based upon hearing of the Subcommittee on Oversight.

C. Budget Effects

1. Committee Estimate

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made relative to the budget impact of by H.R. 3128, as reported by the Committee. The Committee agrees with the cost estimates regarding the spending (outlay) provisions and revenue provisions prepared by the Congressional Budget Office. Some of the revenue provisions were estimated by the Joint Committee on Taxation and are included in the letter prepared by the Congressional Budget Office.

Table 1 below summarizes the budget effects of the spending and tax provisions of the Committee reported bill under the economic assumptions and baseline used in the House-passed fiscal year 1986 budget resolution. The table shows the revenue impact of the Appropriation's Committee (H.R. 3036) action with respect to increases in the number of staff positions in the Internal Revenue Service and the U.S. Customs Service. The estimates in the table reflect the Committee's intention that the number of staff positions in these two agencies not be decreased for fiscal years 1987 and 1988. Following normal budget scorekeeping conventions, the authorizations for these positions are not shown.

Table 2 shows the budget effect for each provision with the bill under the assumptions stated above. The budget effect includes all impacts the provision may have on other programs. For example, many of the Medicare and AFDC provisions have impacts upon the Medicaid program, premiums paid by Part B enrollees of the food stamp program. Simply stated, Table 2 shows the impact of each provision upon the budget deficit. For a more detailed breakout of

the different program effects from a given provision, see the CBO letter.

TABLE 1. SUMMARY OF COMMITTEE ON WAYS AND MEANS DEFICIT REDUCTION BILL (H.R. 3128)

[In millions of dollars]

	Fiscal year—			
	1986	1987	1988	3-year total
Recommendations from:				
Subcommittee on Health [1]	−$2,237	−$3,355	−$4,679	−$10,271
Subcommittee on Trade [1]	−225	−680	−855	−1,760
Subcommittee on Public Assistance and Unemployment Compensation [1]	54	163	214	431
Pension Benefit Guaranty Corporation prosposal	−161	−212	−239	−612
Revenue proposals	−2,011	−2,438	−2,567	−7,016
Total deficit reduction achieved	−4,580	−6,522	−8,126	−19,228

[1] Also includes a revenue item.

Note.—These estimates are from either the CBO or Joint Committee on Taxation. A (−) sign indicates deficit reduction; a positive number indicates a budget deficit increase.

TABLE 2. OUTLAY AND REVENUE PROVISIONS REPORTED BY THE COMMITTEE ON WAYS AND MEANS RELATED TO THE REQUIREMENTS OF THE HOUSE-PASSED FISCAL YEAR 1986 BUDGET RESOLUTION

[In millions of dollars]

Section		Fiscal year—			
		1986	1987	1988	3-year total
	Medicare:				
101	Limit hospital rate of increase	−$1,375	−$1,875	−$2,120	−$5,370
102	Transition to national rates	0	0	0	0
103	Hospital area wage index	(1)	0	0	0
104	Indirect teaching adjustment	−320	−530	−800	−1,650
105	Disproportionate share adjustment	0	0	0	0
106	Rural osteopathic hospitals as rural referral centers	0	0	0	0
107	Direct medical education	0	0	0	0
108	Return on equity payments	−6	−112	−297	−415
109	Allow continued Medicare waivers for certain areas	0	0	0	0
110	Four-year test for State waivers	0	0	0	0
111	Special rule related to donated property	0	0	0	0
112	Report on outliers and transfer policy rural hospitals	0	0	0	0
113	Information on impact of PPS payments	0	0	0	0
121	Hospice extension	(1)	(1)	(1)	(1)
122	Limit the late enrollment penalty for Medicare part A	5	5	5	15
123	Cover newly hired State and local employees under Medicare (revenues).	−53	−191	−293	−537
124	Antidumping provision	0	0	0	0
131	Working Aged Expansion	−225	−344	−383	−952
132	HMO Technical Amendments	0	0	0	0
133	Evaluation of Preadmission Certification Programs	0	0	0	0
134	ESRD networks	0	0	0	0
135	Extension of Certain Medicare HMO demonstration projects.	0	0	0	0
136	Technical corrections	0	0	0	0
141	Physician fee freeze extension	−195	−209	−269	−673
142	Physician payment arm of PROPAC	0	0	0	0
143	Part B premium	0	0	−387	−387
144	Reform fees for hospital-based physicians	0	0	0	0
145	Occupational therapy services	13	17	17	47
146	Payment for durable medical equipment	−30	−58	−89	−177
147	Assistant surgeons' fees for routine cataract operations	−22	−26	−26	−74
148	Limit Medicare payment for cataract surgery	−30	−33	−38	−101
149	Preventive services demonstrations	1	1	1	3

TABLE 2. OUTLAY AND REVENUE PROVISIONS REPORTED BY THE COMMITTEE ON WAYS AND MEANS RELATED TO THE REQUIREMENTS OF THE HOUSE-PASSED FISCAL YEAR 1986 BUDGET RESOLUTION—Continued

[In millions of dollars]

Section		Fiscal year—			
		1986	1987	1988	3-year total
161	Private health insurance continuation	0	0	0	0
	Total	−2,237	−3,355	−4,679	−10,271
	Trade Adjustment Assistance:				
201–231	Reauthorize Firm Program and Amend Worker Program [2]	0	0	0	0
	Customs Service:				
242	Reauthorize and improve operations of Custom Services (revenues).	−150	−450	−615	−1,215
251	User Fees	−75	−230	−240	−545
	Aid to Families with Dependent Children:				
301	Quality control	4	4	62	70
302	Teenage Pregnancy Block Grant	50	100	0	150
303	AFDC for unemployed two-parent families	0	160	250	410
	Railroad Unemployment Compensation:				
401	Increase in railroad unemployment repayment tax (revenues).	0	−101	−98	−199
403	Supplemental unemployment compensation for certain individuals.	(1)	0	0	0
	Revenues:				
501	Improvement in IRS operations	−228	−465	−580	−1,273
502	Cigarette tax made permanent [3]	−1,536	−1,682	−1,686	−4,904
503	Increase in black lung coal excise taxes [3]	−213	−229	−236	−678
504	Tax treatment of rail retirement benefits	−34	−62	−65	−161
	Revenue total	−2,011	−2,438	−2,567	−7,016
	Pension Benefit Guaranty Corporation:				
505	Increase in premiums	−161	−212	−239	−612
	Total deficit reduction	−4,580	−6,522	−8,126	−19,228

[1] Less than $500,000
[2] These provisions of the bill would most likely increase entitlement costs, but no data exist to permit estimating such costs. For a more complete explanation, see the following CBO letter.
[3] Net increase in budget receipts (after income tax offset).
Note.—A (−) sign indicates deficit reduction; a positive number indicates a budget deficit increase.

2. Cost Estimate Prepared by the Congressional Budget Office

In compliance with 2(l)(3)(C) of rule XI of the Rules of the House, requiring a cost estimate prepared by the Congressional Budget Office, the following letter prepared by Congressional Budget Office is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 31, 1985.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means, U.S. House of Representatives Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 3128, the Deficit Reduction Amendments of 1985, as ordered reported by the House Committee on Ways and Means on July 31, 1985.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

RUDOLPH G. PENNER.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 3128.

2. Bill title: The Deficit Reduction Amendments of 1985.

3. Bill Status: As ordered reported by the House Committee on Ways and Means on July 31, 1985.

4. Bill purpose: To make changes in spending and revenue provisions for purposes of deficit reduction and program improvement consistent with the budget process.

5. Estimated cost to the Federal Government: Two federal cost tables are displayed below. The first table shows the costs or savings estimated relative to current law. This is consistent with the standard cost estimate format used by the Congressional Budget Office. Because this bill is intended as a reconciliation act, we have also included a second table displaying estimates relative to the House Budget Committee baseline. The baseline differs from current law primarily in that it assumes the reauthorization of certain programs.

FEDERAL COSTS RELATIVE TO CURRENT LAW

[In millions of dollars]

	By fiscal year—				
	1986	1987	1988	1989	1990
Budget authority	−$345	−$195	−$347	$327	$879
Outlays	−2,296	−3,272	−4,483	−4,794	−5,204
Authorization levels	859	55	58	60	0
Outlays	755	137	70	72	9
Total budget authority/authorization level	514	−140	−289	387	879
Outlays	−1,541	−3,135	−4,413	−4,722	−5,195
Revenues	−1,986	−2,303	−2,378	−2,409	−2,561
Net change to the deficit (outlays less revenues)	−3,527	−5,438	−6,791	−7,131	−7,756

FEDERAL COSTS RELATIVE TO BASELINE

By fiscal year—

[In millions of dollars]

	1986	1987	1988	1989	1990
Budget authority	−$415	−$265	−$417	$257	$879
Outlays	−2,366	−3,342	−4,553	−4,864	−5,204
Authorization levels	66	0	0	0	0
Outlays	58	6	1	1	0
Total budget Authority/authorization level	−349	−265	−417	257	879
Outlays	−2,308	−3,336	−4,552	−4,863	−5,204
Revenues	−1,986	−2,303	−2,378	−2,409	−2,561
Net change to the deficit (outlays less revenues)	−4,294	−5,639	−6,930	−7,272	−7,765

Basis of estimate: The section-by-section cost analysis deals with only those sections of the bill that are anticipated to have a budget impact. The first table provides a section-by-section analysis of the estimated revenue or outlay changes relative to the baseline from the enactment of this legislation. The second table displays estimated changes that would result from current law where current law differs from baseline.

COST ESTIMATES FOR WAYS AND MEANS CHANGES FROM BASELINE: CBO JULY 31,1985

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986–88
TITLE I						
101 Limit Hospital Increase	−1,375	−1,875	−2,120	−2,370	−2,635	−5,370
103 Prohibit Retro. Wage Adjust	*	0	0	0	0	0
104 Reduce Indirect GME	−320	−530	−800	−1,050	−1,160	−1,650
107 Direct GME Freeze Prohibition	0	0	0	0	0	0
108 Reduce return on Equity	−6	−113	−298	−329	−369	−417
Medicaid	0	0	0	0	0	0
Premiums	0	1	1	1	1	2
Total	−6	−112	−297	−328	−368	−415
121 Hospice Ext. and Payment Incr.	(1)	(1)	(1)	(1)	(1)	(1)
122 Reduce Penalties for Delay	5	5	5	5	5	15
123 Medicare Coverage for New State and Local Employees (Revenue)	−53	−191	−293	−394	−537	−537
131 Working Aged	−230	−360	−400	−460	−520	−990
Medicaid	−1	−2	−3	−3	−4	−6
Premiums	6	18	20	22	24	44
Total	−225	−344	−383	−441	−500	−952
141 Physician Fee Freeze:						
Freeze Nonparticipants	−225	−250	−320	−320	−340	−795
Medicaid	−5	−7	−9	−9	−8	−21
Premiums	35	48	60	61	60	143
Total	−195	−209	−269	−268	−288	−673
143 Premiums 25 percent Program 1988	0	0	−407	−568	−603	−407
Medicaid	0	0	20	28	30	20
Total	0	0	−387	−540	−573	−387
144 Reform Fees for HB Docs	0	0	0	0	0	0
145 OT Expanded Service	15	20	20	20	25	55
Medicaid	0	1	1	1	1	2
Premiums	−2	−4	−4	−4	−4	−10
Total	13	17	17	17	22	47
146 DME Rental Freeze	−35	−70	−105	−135	−180	−210
Medicaid	−1	−2	−3	−4	−5	−6
Premiums	6	14	19	25	31	39
Total	−30	−58	−89	−114	−154	−177
147 Assistant Surg/Cataracts	−25	−30	−30	−35	−35	−85
Medicaid	−1	−1	−1	−1	−1	−3
Premiums	4	5	5	5	5	14
Total	−22	−26	−26	−31	−31	−74
148 Prosthetic Lens for Cataract	−35	−40	−45	−50	−60	−120
Medicaid	−1	−1	−1	−1	−2	−3

COST ESTIMATES FOR WAYS AND MEANS CHANGES FROM BASELINE: CBO JULY 31,1985—Continued

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986–88
Premiums	6	8	8	9	10	22
Total	−30	−33	−38	−42	−52	−101
149 Preventative Care Demos	1	1	1	1	1	3
Subtotal Entitlement	−2,184	−3,164	−4,386	−5,161	−5,733	−9,734
Subtotal Authorization	0	0	0	0	0	0
Subtotal Revenue	−53	−191	−293	−394	−537	−537
Deficit Reduction, Title I	−2,237	−3,355	−4,679	−5,555	−6,270	−10,271
TITLE II						
201 Benefits for Firm Relocation	NA	NA	NA	NA		NA
202 Liberalization of Employment Requirements	NA	NA	NA	NA		NA
203 Expansion of TAA Collection Period	NA	NA	NA	NA		NA
211 Petitions	NA	NA	NA	NA		NA
213 Technical Assistance	NA	NA	NA	NA		NA
221 Reauthorization of Current Program:						
Cash Benefits	0	0	0	0		0
Firm Assist. (Authorization)	0	0	0	0	0	0
Empl. Services (Authorization)	0	0	0	0		0
241 International Trade Commission (Authorization)	3	(1)	(1)			3
242 Customs Service (Authorization)	55	6	1	1		62
242 Customs Service (Revenue)	−150	−38				−188
243 U.S. Trade Rep. (Authorization)	(1)	(1)				(1)
251 Customs User Fees	−75	−230	−240	−170		−545
Subtotal Entitlement	−75	−230	−240	−170	0	−545
Subtotal Authorization	58	6	1	1	0	65
Subtotal Revenue	−150	−38	0	0	0	−188
Deficit Reduction, Title II	−167	−262	−239	−169	0	−668
TITLE III						
301 Revise AFDC Quality Control	4	4	62	182	229	70
302 Block Grant For Teenage Pregnancy	50	100				150
303 Mandate AFDC Unemployed:						
Parent Program		100	160	180	185	260
Medicaid		95	150	175	185	245
Food Stamps		−35	−60	−70	−70	−95
Total	0	160	250	285	300	410
Subtotal Entitlement	54	264	312	467	529	630
Subtotal Authorization	0	0	0	0	0	0
Subtotal Revenue	0	0	0	0	0	0
Deficit Reduction, Title III	54	264	312	467	529	630
TITLE IV						
401 Railroad Retirement Unemployment Repayment Tax (Revenue)	0	−101	−98	−4	0	−199
403 Supp. Unemployment Comp.	(1)	0	0	0	0	0
Subtotal Entitlement	0	0	0	0	0	0
Subtotal Authorization	0	0	0	0	0	0
Subtotal Revenue	0	−101	−98	−4	0	−199
Deficit Reduction, Title IV	0	−101	−98	−4	0	−199
TITLE V						
502 Cigarette Tax Ext. (Revenue)	−1,536	−1,682	−1,686	−1,700	−1,705	−4,904
503 Increase Excise Tax on Coal (Revenue)	−213	−229	−236	−246	−256	−678

COST ESTIMATES FOR WAYS AND MEANS CHANGES FROM BASELINE: CBO JULY 31,1985—Continued

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986–88
504 Portion of RR Benefits Not Equivalent to SS Benefits Taxed as Ordinary Pension (Revenue)	−34	−62	−65	−65	−63	−161
505 Increase PBGC Premiums	−161	−212	−239	0	0	−612
Subtotal Entitlement	−161	−212	−239	0	0	−612
Subtotal Authorization	0	0	0	0	0	0
Subtotal Revenue	−1,783	−1,973	−1,987	−2,011	−2,024	−5,743
Deficit Reduction, Title V	−1,944	−2,185	−2,226	−2,011	−2,024	−6,355
Total Entitlement	−2,366	−3,342	−4,553	−4,864	−5,204	−10,261
Total Authorization	58	6	1	1	0	65
Total Revenue	−1,986	−2,303	−2,378	−2,409	−2,561	−6,667
Deficit Reduction, all Title	−4,294	−5,639	−6,930	−7,272	−7,765	−16,863

[1] Less than $500,000.
NA—Not available.
Note.—Revenue increases appear as negative numbers beause they reduce the deficit.

The following table shows changes from current law, where current law is not equal to baseline.

COST ESTIMATES FOR WAYS AND MEANS: CBO JULY 31, 1985

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986–88
221 Reauthorization of Current Program:						
Cash Benefits	70	70	70	70		0
Firm Assist. (Authorization)	17	24	28	29	9	0
Empl. Services (Authorization)	27	28	30	31		0
241 International Trade Commission (Authorization)	27	2	(1)			29
242 Customs Service (Authorization)	672	81	12	12		765
243 U.S. Trade Rep. (Authorization)	12	2				14
Total Entitlement	70	70	70	70	0	0
Total Authorization	755	137	70	72	9	808
Total Revenue	0	0	0	0	0	0
Deficit Reduction	825	207	140	142	9	808

[1] Less than $500,000.

TITLE I—MEDICARE

Section 101. The increase in the DRG rates for PPS hospitals on October 1, 1985 is fixed at 1 percent in this bill. Although the Administration has issued proposed regulations to freeze DRG rates during FY 1986, the baseline assumes a 5.6 percent increase. We estimate this bill would cost an additional $305 million in 1986 and $1.2 billion from 1986 through 1988 when compared to the proposed regulations.

Section 102. The transition to national DRG rates is frozen for one year. The freeze affects the allocation of payments but not the total amounts. Specifically, less efficient hospitals and those hospitals in higher cost regions will receive higher payments at the expense of more efficient hospitals and hospitals in lower cost re-

gions. The effects of this freeze on other provisions is explicitly accounted for in the CBO estimate for each provision affected by the freeze.

Section 104. The method of payment to hospitals for the indirect costs of teaching programs is reduced under this section. Although the savings for this provision above are $1,830 million during fiscal years 1986–88, the gross savings are reduced by $180 million to reflect payments to teaching hospitals under Section 105.

Section 105. The formula for the computation of payments for disporportionate share redistributes $670 million from hospitals with few low-income patients to those with many. The gross costs of this provision are reduced to zero by the $180 millon in savings taken from Section 104 and by additional reductions in payments to hospitals with few low-income patients.

Section 107. The recently promulgated regulation freezing payments for Graduate Medical Education (GME) is not included in baseline Medicare outlays. Therefore, prohibiting the regulation is not a cost against baseline. CBO estimates that the prohibition results in $130 million higher outlays in 1986 and $45 million higher in 1987 compared with the Administration's freeze.

Section 108. The savings are based on our estimate that payments for returns on equity (ROE) will be approximately $280 million in FY 1986. Payments to hospitals for ROE are eliminated for hospital fiscal years beginning after October 1, 1986. Payments to outpatient departments, nursing homes and home health agencies are reduced by a third beginning with institutional fiscal years beginning after October 1, 1985. The pattern of savings reflects the later effective date for the inpatient provision as well as the fact that proprietary hospitals have fiscal years that typically begin near the end of the federal fiscal year.

Section 121. Extending the hospice provision with higher than current rates results in additional outlays of less than $500,000 annually. An extension of the hospice provision without increasing the rates would save approximately $15 million during FY 1986–88. The cost of increasing the rates slightly more than offsets the savings from extending the program.

Section 123. Coverage of state and local workers. Section 123 extends Medicare coverage (Part A) to all state and local employees hired after December 31, 1985. Any state or local employee who leaves state or local employment and is later rehired by a state or local government is considered a new employee for purposes of this provision. This provision is effective January 1, 1986. The revenue increases are shown in the table. Over a five-year period, the outlay increases are insignificant.

Section 131. This section extends the working aged provisions of the Social Security Act to workers 70 years or older and their spouses. Three types of individuals are included in this provision: workers 70 or older, spouses over 65 of workers 70 or older, and spouses over 70 of workers under 65. By making Medicare a secondary payer for these workers and spouses, Medicare outlays would be reduced by an estimated $990 million during the period 1986 to 1988.

Section 141. Physician Fee Freeze. Under current law, the customary and prevailing charges for all physician services are frozen for

a 15-month period which expires on October 1, 1985. During this period, nonparticipating physicians are prohibited from charging their Medicare beneficiaries more than they charged during a base period from April through June 1984.

This bill would extend the freeze for an additional 12-month period, expiring on October 1, 1986, for nonparticipating physicians only. The current prohibition on increases in actual charges of nonparticipating physicians would also be extended for 12 months, beginning October 1, 1985. On October 1, 1986, any physician who signs a participation agreement effective for the year beginning October 1, 1986 would receive an increase in Medicare payments. For physicians not signing a participation agreement, increases in the prevailing will be lagged one year behind those of participating physicians.

The CBO assumes that with the additional 12-month freeze, 50 percent of the reasonable charges for physicians will be participating dollars. This represents a shift of approximately 22 percent of non-participating reasonable charges to participating, based on the assumption that the 15-month freeze results in 35 percent of the reasonable charges being participating, and 65 percent, nonparticipating.

While participating physicians would be receiving allowed charges equivalent to amounts that would have been received by 1987 in the absence of any freeze, nonparticipating physicians who refused to participate in 1986 would not catch up to prefreeze reimbursements until 1990.

The Secretary would also be required to transfer $15 million in Medicare Part B funds to the carriers for continued administration of the freeze and the participating physician program, and for the development of professional relations staffs dedicated exclusively to addressing the billing and other problems of participating physicians.

Section 143. Increasing Part B Premiums. Currently, premiums are set at 25 percent of SMI program costs for calendar years 1986 and 1987, and then based on COLA's for calendar years 1988, 1989, and 1990. Under this provision, premiums will be set at 25 percent of SMI program costs for calendar year 1988, changing the estimated monthly premium amount from $19.40 to $20.80 for that year.

Section 145. Occupational Therapists. This provision gives the same coverage under Medicare Part B for occupational therapists (OT) as is currently allowed for physical therapists (PT) for the three settings. The costs of coverage of OT services under Medicare for the private practice and SNF settings was based on Medicare payment data for PT services. The CBO estimate of the federal costs of extending Medicare coverage to OT's in rehabilitation agencies is based on the number of OT's in this particular setting relative to those in skilled nursing facilities.

Section 146. Durable Medical Equipment (DME) Rental Freeze. A one percent cap will be placed on the prevailing and customary charges for all rental durable medical equipment in fiscal year 1986. The prevailing charges for both rental and purchased DME would be increased thereafter by the CPI.

Section 147. Assistants Surgery Services for Routine Cataract Operations. This estimate was based on the Office of the Inspector

General (OIG) Audit Report dated June 7, 1985. For the 29 states included in their review, there were about 576,000 cararact operations paid by Medicare for inpatient and outpatient operations during calendar year 1983, of which about 88,000 operations had additional payments for assistant surgeon charges at a cost of approximately $33 million.

Section 148. Prosthetic Lens for Cataracts. The CBO based its estimate on a General Accounting Office (GAO) study that gathered data from 7 carriers in 1982. The estimate has two components: the savings from a uniform screen limiting the number of replacement lenses that Medicare will pay for and the establishment of a reasonable charge allowance for prosthetic lenses and for the related professional service.

The estimated savings are based on cost data contained in the GAO study. CBO has attempted to extrapolate the data from the seven carriers examined in the GAO study to a national estimate.

Section 149. The demonstration program will fund no fewer than five demonstrations. Based on proposals submitted to DHHS the five projects are expected to average $200,000 each for an annual total of $1,000,000.

TITLE II—TRADE AND CUSTOMS LAWS AMENDMENTS

Section 201-205. The bill would make several changes to the worker adjustment assistance segment of the Trade Adjustment Assistance program. The provisions (1) providing benefits to workers whose firms have relocated overseas, (2) liberalizing employment requirements, and (3) expanding the period during which workers can receive benefits would probably increase costs, but no data exist to permit estimating the magnitude of such costs. The first of these three provisions has the potential to substantially increase spending. According to a paper written by Robert H. Frank and Richard T. Freeman for a 1978 Department of Labor conference on trade and employment—The Distributional Consequences of Direct Foreign Investment—every $1 billion of direct private U.S. foreign investment seems to eliminate about 26,500 domestic jobs, both potential and existing. About $4.5 billion of private U.S. capital was invested abroad in 1984. Based upon the above formulation, if U.S. firms were to transfer $1 billion of their existing plant and equipment investment abroad and if all U.S. workers who lost their jobs as a result were to apply for trade adjustment benefits, we estimate that the cash benefit program could double in size.

Section 211-215. The bill would also make several changes affecting the eligibility and terms of the technical and financial assistance provided to firms that have been adversely impacted by competition from imported products.

It would expand eligibility for trade adjustment assistance to certain firms that experience a decline in sales and/or production of a critical product line. It would also eliminate the requirement that firms share in the cost of post-certification diagnostic and adjustment assistance, although it would not change the cost-sharing formula for implementation assistance. These two changes are likely to increase the demand from firms for assistance, although it is not possible at this time to estimate precisely this additional demand.

Furthermore, while appropriations could be increased, perhaps by several million dollars, to accommodate this demand, this would not necessarily be the case. For example, if the Congress did not provide additional funds to meet increased demand, fewer firms could be served, or the queue for assistance could lengthen, or the mix of assistance could be modified. Because of the uncertainty regarding the future level of appropriations for this program, the cost estimate reflects only the CBO baseline estimates for trade adjustment assistance to firms.

Section 221. The estimated costs of reauthorizing the current law individual cash benefit, training, and firm aid parts of the trade adjustment assistance program are consistent with the assumptions underlying the HBC baseline. Based upon recent certification levels, it is assumed that approximately 45,000 individuals will be certified under the cash benefit part of the program in fiscal year 1985, that 25,000 of these will receive first payments in fiscal year 1986, and that each will draw payments for an average of about 22 weeks. The estimates for the training and firm assistance portions of the program are based upon fiscal year 1985 appropriated levels that are inflated through time.

Section 241. The bill authorizes the appropriation of $28.9 million for the International Trade Commission for fiscal year 1986. Outlays were estimated using historical outlays rates.

Section 242 authorizes the appropriation of $777 million for the U.S. Customs Service for fiscal year 1986. This includes salaries and expenses for 800 new Customs Service personnel—500 inspectors, 150 import specialists, 100 customs patrol officers, and 50 special agents—to improve enforcement and compliance. Additional revenues generated by the new agents are estimated to be $150 million in 1986 and $38 million in 1987.

If the additional personnel continue to be employed by the Customs Service after 1986, costs to the federal government would be about $30 million annually above baseline levels. Because the additional staffing would result in stricter enforcement and greater voluntary compliance, the government would collect additional revenues of $412 million in 1987 and $615 million each year thereafter.

Section 243. The authorization level for the Office of the U.S. Trade Representative is stated in the bill, and outlay estimates are based on historical spending patterns.

Section 251. Custom User Fees. The bill would require the Secretary of the Treasury to charge and collect fees to offset the costs of processing arrivals into the customs territory of the United States. Such fees, which vary in amount, would be charged for each arrival of a commercial vessel of 100 or more tons, a commercial truck, a railroad car, or a passenger aboard a commercial vessel, commercial aircraft, or train. An annual fee of $25 would also be charged for all arrivals of private aircraft or private vessels. Assuming this bill is enacted on October 1, 1985, the Customs Service would begin to collect the fees 180 days later and would continue to collect them until April 1, 1989. The estimate of the amount of fees collected is based on projections of future arrivals which were derived from historical data on the number of arrivals in each category for recent years. It also reflects the loss of about $25 million a year in

overtime fees that the Customs Service would collect under current law, but would be prohibited from collecting by the bill.

Based on information from the Customs Service, we expect that no significant additional costs would result from collecting the fees, because the necessary administrative structure already exists. The advisory committee that the bill would establish would result in additional costs of about $30,000 per year.

TITLE III—AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Section 301. Revise AFDC Quality Control. The current quality control system imposes fiscal sanctions on the states when their erroneous payments exceed certain tolerance levels. This bill would make major revisions in the quality control system so as to reduce the states' liabilities for sanctions. The basic error rate tolerance level would be increased from 3 percent to 3.5 percent. For states with an AFDC-UP program, with a higher than average percentage of earners on AFDC, and with a higher than average population density, the tolerance level would be increased further—to as high as 5.0 percent. At the same time, the measured error rate would be reduced. Technical errors—such as failure to get a Social Security number—would not be counted, and the estimated error rate for states with large sample sizes would be the lower bound rather than the midpoint of the range within which a state's true error rate falls. Finally, states would be allowed to choose an automatic waiver of their sanction if they were to spend additional administrative funds equal to one-half of their sanction amount on reducing error rates.

These changes would reduce expected fiscal sanctions by about three-quarters. Over the 1986–1990 period, federal costs would be an estimated $481 million. These costs were based on reductions in the fiscal sanctions that CBO assumes would be collected under current law. Fiscal 1981 and 1982 sanctions are assumed to be collected in 1988; 1983 and 1984 sanctions in 1989; and 1985 and 1986 sanctions in 1990. The fiscal year 1981 sanctions have been assessed but CBO assumes they will not be collected until states have exhausted their judicial recourse. Further, CBO assumes that only 50 percent of the 1981 through 1983 sanction amounts will be collected and that only one-third of sanction amounts after 1983 will be collected because of waivers or court decisions.

Section 302. Authorize Grant to Reduce Teenage Pregnancy. In an attempt to reduce teenage pregnancies, the bill would authorize an appropriation of $50 million in 1986 and $100 million in 1987 for grants to states to be used to provide specified services targeted on young AFDC mothers who had not completed high school. The CBO estimates assumes that all the funds authorized would in fact be appropriated.

Section 303. Mandate AFDC-UP Program. Under current law, states may provide assistance to two-parent families in which the primary earner is unemployed. Twenty-four states and the District of Columbia provide such assistance. This bill would require the remaining 26 states to do so, effective October 1, 1985.

The CBO estimates that about 75,000 two-parent families would become new AFDC participants as a result of this provision. Their

benefits would average an estimated $235 a month in 1987. Not all of the new participants would come onto AFDC immediately. CBO has assumed that on average during 1987 about 63 percent of these families would participate and during 1988, 95 percent. The federal share of benefit payments would be $85 million in 1987 and $160 million in 1990. Administrative costs would also rise because of the increase in participating families; the federal share of these costs would be estimated $15 million in 1987 and $25 million in 1990.

The estimates of new families and their average benefits were based on simulations from the Transfer Income Model (TRIM2). TRIM2 simulates numbers of families eligible for AFDC under current law and under alternative legislative changes, using income an demographic information reported in the Current Population Surveys of the Bureau of the Census. The TRIM2 estimates of families, based on 1984 incomes, were adjusted downward to allow for declining unemployment rates from 1984 to 1987.

TITLE IV—RAILROAD UNEMPLOYMENT TAX AND UNEMPLOYMENT COMPENSATION

Section 401 would increase the Railroad Retirement Unemployment Insurance (RRUI) repayment tax rates. The Railroad Retirement Solvency Act of 1983 established a repayment tax on the first $7,000 in wages paid to a rail employee effective July 1, 1986 through September 30, 1990. Under current law the tax rate starts at 2.0 percent and will be increased by 0.3 percent a year. The bill would increase the initial tax rate by 2.3 percentage points in 1986, by 2.4 percentage points in 1987, and by 3.4 percentage points in 1988. That is, the bill would change the tax rates from 2.0 percent to 4.3 percent in 1986, from 2.3 percent to 4.7 percent in 1987, from 2.6 percent to 6.0 percent in 1988 and would retain the current law rates of 2.9 percent in 1989 and 3.2 percent in 1990. Estimated revenue effects appear in the table.

The bill would also extend the RRUI Account's authority to borrow from the Railroad Retirement Account effective October 1, 1985. In addition, the bill would impose a 3.5 percent surcharge on an annual wage base on $7,000 if the RRUI Account has to borrow from the retirement account. Under current assumptions, the RRUI account will not need to borrow from the retirement account before 1991, therefore this provision has no revenue effect over the estimating period.

TITLE V—REVENUE PROVISIONS

Section 501 of Title V consists of a "sense of the Congress" statment that the Administration's proposed cuts in the Internal Revenue Service (IRS) budget should be restored and funds for revenue enforcement and related purposes should be increased to the levels recommended by the Committee on Appropriations. Because a "sense of the Congress" statement by itself does not achieve these actions, this cost estimate, therefore, shows no budgetary effects.

If the Treasury, Postal Service, and General Government Appropriation bill reported out of the Committee on Appropriations on July 18, 1985 were enacted and the staffing levels provided by that bill were maintained through 1990, then the associated costs and

the revenue collections resulting from increases in the IRS's Examinations staff would be:

[By fiscal year, in millions of dollars]

Increases relative to the baselines	1986	1987	1988	1989	1990
Outlays	31	34	35	37	39
Revenues	228	465	580	640	708

These revenue effects agree with those estimated by the Joint Committee on Taxation.

Section 502 would make permanent the 16 cents per pack exicise tax on cigarettes enacted under TEFRA. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) temporarily increased the excise tax on cigarettes from 8 cents per pack to its present rate of 16 cents per pack over the period January 1, 1983 to September 30, 1985. Under current law the tax on cigarettes is scheduled to return to 8 cents per pack on October 1, 1985. The bill would also create the "Tobacco Equilization Trust Fund" and would dedicate a portion of cigarette tax revenues to this fund. The amounts in the fund could be used for the tobacco price support program.

Section 503 would increase the excise tax on coal used to finance the Black Lung Disability Trust Fund. Under current law, the manufacturers excise tax on domestically mined coal other than lignite is $1 per ton for coal from underground mines and $.50 per ton for coal from surface mines, but in no case can the tax exceed four percent of the sale price. This bill would increase the tax on underground mined coal to $1.50 per ton and on surface mined coal to $.75 per ton effective January 1, 1986 through December 31, 1990 and would raise the tax limit to maximum of 6 percent of the sale price of a ton of coal. From January 1, 1991 through December 31, 1995 the tax on underground mined coal would be $1.60 and the tax on surface mined coal would be $.80; the tax limit would be 6.4 percent of the sale price. After 1995, tax rates and the limit would revert to their 1986–1990 levels if loans made to the Black Lung Disability Trust Fund are repaid.

Section 504 would treat the portion of Tier 1 Railroad Retirement benefits that are not equivalent to Social Security benefits as ordinary pension income for the purposes of individual income taxation. Under current law, both Tier 1 benefits that are equivalent to Social Security and those are not equivalent are taxed as Social Security benefits are taxed. This provision would be effective for benefit payments made after December 31, 1985.

The CBO has reviewed and concurs with the estimated revenue effects of Sections 502, 503, and 504 of the bill prepared by the Joint Committee on Taxation. Net revenue effects (after offsets for income tax changes in the excise tax estimates) are shown in the detailed baseline table.

Section 505. The bill would increase the Pension Benefit Guarantee Corporation's (PBGC) single-employer pension plan monthly premium from $2.60 to $8.00 per participant for plan years beginning after December 31, 1985 and after January 1, 1989. Increasing

the single-employer premium from $2.60 to $8.00 would result in an additional $5.40 per participant in premium income. The increased premium collections would be credited to the public enterprise fund and a reduction in outlays would result.

6. Estimated cost to the State and local governments: Several Titles of this bill would have an effect on state and local government budgets. These estimated effects are shown in the following table.

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Title I-Medicaid	−7	−10	3	9	9
Title I–HI Tax for S&L	26	96	147	197	269
Title III	*	125	140	50	15
Total estimated State and local outlays	19	211	290	256	293

*Less than $2.5 million.

Basis of Estimate:

Title I, which reduces expenditures in the Medicare program, would change Medicaid outlays. Because states share in the financing of Medicaid—paying about 55 percent of outlays—their expenditures would change. Reductions in Medicare outlays reduce state and local copayments for those beneficiaries with dual Medicare/Medicaid coverage. The increased Medicare premiums are a cost to state Medicaid programs. Beginning in FY 1988, the additional premiums are larger than savings from federal Medicare cut backs. State and local government will also have to pay the employers' share of the Hospital Insurance tax for new state and local employees.

Title III, which changes the AFDC program, would on balance increase states and local expenditures. The revision of AFDC quality control to reduce the states' liabilities for sanctions would lower expenditures in the same amount as the rise in federal expenditures. The grant to reduce teenage pregnancy would have no effect on states and localities; the bill requires that state spending supplement, and not replace, current spending on related programs. Finally, the requirement that states establish an AFDC–UP program would increase state and local expenditures, by $125 million in 1987 and $235 million in 1990. States share in the financing of AFDC and Medicaid outlays, which rise because of the AFDC–UP mandate. The state share of AFDC–UP benefits is estimated to be 63 percent; of Medicaid 61 percent; and of program administrative costs 50 percent.

Title IV would alter the tax treatment of certain Railroad Retirement benefits. States whose income tax bases depend on the federal income tax base may experience small state income tax increases because of the new tax treatment of some Railroad Retirement benefits.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Diane Burnside, Marianne Deignan, Neil Fisher, Debra Goldberg, Jim Hearn, Dick Hendrix, Steve Long, Mary Maginniss, Anne Manley, Kathleen O'Connell, Jan Peskin, Linda Radey, Jack Rodgers, and Steve Sheingold.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

3. New Budget Authority and Tax Expenditures

In compliance with subdivision (B) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the Committee advises that the Congressional Budget Office cost estimate included above indicates that there is a reduction in new budget authority relative to baseline of $349 million for fiscal year 1986 and there are no increased tax expenditures as a result of this bill.

D. Oversight by Committee on Government Operations

In compliance with subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings or recommendations have been submitted to this Committee by the Committee on Government Operations, regarding the provisions contained in this bill.

E. Inflation Impact

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that H.R. 3128, as reported, will reduce the Federal deficit by $4.6 billion in fiscal year 1986, $6.5 billion in fiscal year 1987, and $8.1 billion in fiscal year 1988. The Committee believes that this reduction in the federal deficit, totaling $19.2 billion over the three-year period of fiscal year 1986–1988, will have no inflationary impact on the economy, and may contribute to lower health prices and consumer prices generally.

IV. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

DEFINITION OF EMPLOYMENT

Sec. 210. For the purposes of this title—

Employment

(a) * * *

* * * * * * *

[Medicare Qualified Federal Employment

[(p) For purposes of sections 226 and 226A, the term "medicare qualified Federal employment" means any service which would constitute "employment" as defined in subsection (a) of this section but for the application of the provisions of subsection (a)(5).]

MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT

(p)(1) For purposes of sections 226 and 226A, the term "medicare qualified government employment" means any service which would constitute "employment" as defined in subsection (a) of this section but for the application of the provisions of—

(A) subsection (a)(5), or

(B) subsection (a)(7), except as provided in paragraphs (2) and (3).

(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is preformed—

(A) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(B) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

(D) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this paragraph, the terms "State" and "political subdivision" have the meanings given those terms in section 218(b).

(3) Service performed for an employer shall not be treated as employment by reason of paragraph (10)(B) if—

(A) such service would be excluded from the term "employment" for purposes of this section if paragraph (1)(B) did not apply;

(B) such service is performed by an individual—

(i) who performing substantial and regular service for remuneration for that employer before January 1, 1986,

(ii) who is a bona fide employee of that employer on December 31, 1985, and

(iii) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(C) the employment relationship with that employer has not been terminated after December 31, 1985.

(4) For purposes of paragraph (3), under regulations (consistent with regulations established under section 3121(u)(2)(D) of the Internal Revenue Code of 1954)—

(A) all agencies and instrumentalities of a State (as defined in section 218(b)) or of the District of Columbia shall be treated as a single employer, and

(B) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in subparagraph (A).

* * * * * * *

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

SEC. 226. (a) Every individual who—

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 202, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of title XVIII,

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if [medicare qualified Federal employment] *medicare qualified government employment* (as defined in section 210(p)) were treated as employment (as defined in seciton 210(a)) for purposes of this title, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (1), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Every individual who—

(1) has not attained age 65, and

(2)(A) * * *

* * * * * * *

(C)(i) * * *

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this title), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) [medicare qualified Federal employment] *medicare qualified government employment* (as defined in section

210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and

* * * * * * *

(g) The Secretary and Director of the Office of Personnel Management shall jointly prescribe and carry out procedures designed to assure that all individuals who perform [medicare qualified Federal employment] *medical qualified government employment by virtue of service described in section 210(a)(5)* are fully informed with respect to (1) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (2) the requirements for and conditions of such eligibility, and (3) the necessity of timely application as a condition of entitlement under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity under chapter 83 of title 5, United States Code, or under another similar Federal retirement program, and whose eligibility for such an annuity is or would be based on a disability.

* * * * * * *

SPECIAL PROVISIONS RELATING TO COVERAGE UNDER MEDICARE PROGRAM FOR END STAGE RENAL DISEASE

SEC. 226A. (a) Notwithstanding any provision to the contrary in section 226 or title XVIII, every individual who—

(1)(A) is fully or currently insured (as such terms are defined in section 214), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974) after December 31, 1936, were included within the meaning of the term "employment" for purposes of this title, and (ii) his medicare qualified [Federal] *government* employment (as defined in section 210(p)) were included within the meaning of the term "employment" for purposes of this title;

(B)(i) is entitled to monthly insurance benefits under this title, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974, or (iii) would be entitled to a monthly insurance benefit under this title if medicare qualified [Federal] *government* employment (as defined in section 210(p)) were included within the meaning of the term "employment" for purposes of this title; or

(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);

(2) is medically determined to have end stage renal disease; and

(3) has filed an application for benefits under this section;

shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of title XVIII, subject to the deductible, premium, and coinsurance provisions of that title.

* * * * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * * * *

STATE PLANS FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN

SEC. 402. (a) A State plan for aid and services to needy families with children must—

(1) * * *

* * * * * * *

(38) provide that in making the determination under paragraph (7) with respect to a dependent child and applying paragraph (8), the State agency shall (expect as otherwise provided in this part) include—

(A) any parent of such child, and

(B) any brother or sister of such child, if such brother or sister meets the conditions described in clauses (1) and (2) of section 406(a), if such parent, brother, or sister is living in the same home as the dependent child, and any income of or available of such parent, brother, or sister shall be included in making such determination and applying such paragraph with respect to the family (notwithstanding section 205(j), in the case of benefits provided under title II); **[**and**]**

(39) provide that in making the determination under paragraph (7) with respect to a dependent child whose parent or legal guardian is under the age selected by the State pursuant to section 406(a)(2), the State agency shall (except as otherwise provided in this part) include any income of such minor's own parents or legal guardians who are living in the same home as such minor and dependent child, to the same extent that income of a stepparent is included under paragraph (31) **[**.**]**; *and*

(40) provide that payments of aid will be made under the plan with respect to dependent children of unemployed parents, in accordance with section 407.

The Secretary may waive any of the requirements imposed under or in connection with paragraphs (13) and (14) of this subsection to the extent necessary to make such requirements compatable with the corresponding reporting and budgeting requirements by the Food Stamp Act of 1977.

* * * * * * *

PAYMENT TO STATES

SEC. 403. (a) * * *

* * * * * * *

[(i)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments (as defined in subparagraph (C))

to its total payments under the State plan approved under this part exceeds—

[(i) 0.04 for fiscal year 1983, or

[(ii) 0.03 for any fiscal year thereafter,

then the Secretary shall make no payment for such fiscal year with respect to so much of the erroneous excess payments (as so defined) as exceeds the allowable error rate for such fiscal year.

[(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a fiscal year despite a good faith effort by such State.

[(C) For purposes of this subsection, the term "erroneous excess payments" means the total of (i) payments to ineligible families, and (ii) overpayments to eligible families.

[(2) The State agency administering the plan approved under this part shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

[(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

[(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rate for a fiscal year, the amount that would otherwise be payable to such State under this part for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

[(4) This subsection shall not apply with respect to Puerto Rico, Guam, or the Virgin Islands.]

(i)(1)(A) In order to establish and maintain improved quality control standards and procedures in the operation and administration of State plans approved under this part—

(i) each State, in accordance with a timetable and standards which shall be established by the Secretary in regulations, shall—

(I) collect a statistically reliable sample of the cases under its approved State plan under this part for each fiscal year or (at the option of the State) for each of the two six-month periods in such year, for purposes of quality control review under this subsection,

(II) review the sample so collected and (on the basis of such review) make its original findings with respect to errors for the period involved, and

(III) Submit such findings to the Secretary;

(ii) the Secretary, after studying the State's original findings as submitted under clause (i)(III), shall select specified cases for further review and notify the State thereof; and the State shall

submit to the Secretary the records of the cases so selected and specified.

(iii) the Secretary shall review and analyze the case records submitted under clause (ii) and (on the basis of such review and the State's original findings) shall determine the State's error rate for the period involved (without any adjustment under paragraph (2)(C)) and notify the State of such error rate within six months after the close of the fiscal year or within six months after the date on which the sample is submitted, whichever is later; and

(iv) the State shall develop and submit to the Secretary (except as provided by subparagraph (B)) a corrective action plan for eliminating or reducing errors identified as a result of the reviews under clauses (i) and (iii) (whether or not such errors are subject to inclusion for purposes of disallowances under paragraph (2)(A)) and, after such plan has been reviewed and approved by the Secretary in accordance with subparagraph (C), shall implement the corrective actions provided for in such plan in accordance with a timetable established by the Secretary in regulations; and the Secretary shall continuously monitor the State's corrective action process under such plan.

(B) The requirement (in subparagraph (A)(iv)) that States submit corrective action plans for eliminating or reducing errors may be waived by the Secretary in the case of any State which has consistently had an error rate below its error rate tolerance level (as determined by the Secretary, upon the request of the State, in the manner provided in subparagraphs (B) and (C)(i) of paragraph (2)).

(C) The Secretary shall establish criteria for corrective action plans submitted by States under subparagraph (A)(iv), and shall approve any plan so submitted upon determining that it meets such criteria. If a plan so submitted is disapproved, the Secretary shall specify (in notifying the State of such disapproval) the respect or respects in which the plan fails to meet the criteria so established, and shall provide appropriate advice and assistance to the State in eliminating such failure with the objective of facilitating the resubmission and approval of the plan at the earliest possible time.

(D) The sample obtained under subparagraph (A)(i) by a State which collected such sample on an annual basis rather than electing to collect two six-month samples for the fiscal year involved shall in no case include a smaller number of cases than the number that the Secretary determines would be required for a statistically reliable sample if the State had elected to collect two six-month samples for that fiscal year.

(E) The requirements imposed upon a State by subparagraph (A) with respect to the collection and review of samples and the submission of the results thereof, and the requirement that a State (under subparagraphs (A)(iv) and (C)) submit a corrective action plan which meets the Secretary's criteria established under subparagraph (C), shall be deemed for purposes of section 404 to be included in the State's plan approved under section 402.

(2)(A) Notwithstanding subsection (a)(1) but subject to subparagraph (C) and paragraph (3)), if a State's error rate for any fiscal year (as defined in paragraph (5)(A)) exceeds the error rate tolerance level determined for the State (for that year) under subparagraph

(B), then the Secretary shall disallow Federal payments for such fiscal year with respect to the State's erroneous payments (as defined in paragraph (5)(B)) to the extent that the inclusion of such erroneous payments in determining the State's error rate caused such rate to exceed the tolerance level so determined.

(B) A State's error rate tolerance level for any fiscal year shall be 3.5 percent, increased by—

(i) 0.5 percentage points if, throughout such fiscal year, the plan of such State approved under this part provides for the payment of aid with respect to dependent children of unemployed parents as provided in section 407,

(ii) 0.1 percentage points for each full 20 percent increment (up to a maximum of five such increments) by which (I) the ratio of the number of families with earned income who are receiving aid under such State's plan approved under this part to the total number of families receiving such aid exceeds (II) the average ratio, per State, of the number of families with earned income who are receiving aid under all of the State plans approved under this part to the total number of families receiving such aid, and

(iii) 0.1 percentage points for each full 20 percent increment (up to a maximum of five such increments) by which (I) the population per square mile of land area in such State exceeds (II) the average population per square mile of land area, per State, in all of the States having plans approved under this part.

(C) In determining the error rate in any State for purposes of this paragraph—

(i) such rate shall be fixed at the midpoint of the standard interval for errors within which the State's true error rate falls (as determined without regard to this clause on the basis of the sample or samples collected by the State under paragraph (1)(A)(i)), or at the lower bound of such standard interval in the case of a State which has collected a sample or samples sufficiently large to produce a lower limit of such interval no more than 2.5 percentage points below the midpoint; and

(ii) errors which are technical in nature, and which would not change the AFDC payment levels involved, shall be disregarded.

For purposes of clause (i), the lower limit of the standard interval for errors within which a State's true error rate falls shall be calculated in accordance with regulations prescribed by the Secretary to adjust for variability among the States in the number, proportion, or dollar value of cases in which the State's findings under paragraph (1)(A)(i)(II) (with respect to errors in its sample or samples collected under paragraph (1)(A)(i)(I)) differ from the Secretary's findings with respect to the State's error rate under paragraph (1)(A)(iii).

(D) The total amount of the disallowances that would otherwise be imposed with respect to any State under subparagraph (A) on account of an error rate in excess of the applicable error rate tolerance level for any fiscal year shall be reduced by the Federal share of any overpayments collected by such State (on account of erroneous payments) during that fiscal year.

(3)(A) The Secretary, in accordance with this paragraph, may waive all or any part of any disallowance that would otherwise be

imposed with respect to a State under paragraph (2)(A) if such State is unable to reach the applicable error rate tolerance level for the fiscal year involved despite a good-faith effort by such State.

(B) Any State may request a waiver of all or part of any disallowance that would otherwise be imposed with respect to such State for any fiscal year under paragraph (2)(A), basing such request upon a showing—

(i) that the State has made (and is continuing to make) a good-faith effort to reduce or eliminate the erroneous payments involved but was unable to reach the applicable error rate tolerance level for such fiscal year despite that effort; or

(ii) that (I) the Secretary's determination of the State's error rate for such fiscal year was made incorrectly or in a manner inconsistent with the provisions of this subsection, and (II) the State's error rate, if determined correctly and in a proper manner, would be lower than the rate so determined by the Secretary.

The Secretary shall consider and review such request, and either approve it or disapprove it in whole or in part, in accordance with a timetable which shall be specified in regulations. If the Secretary disapproves the request, the State may appeal the Secretary's decision to the Grant Appeals Board in the Department of Health and Human Services for such further action as may be provided for by law or regulations (including judicial review of the Secretary's decision or the Board's determination).

(C) In considering and reviewing any request for a waiver submitted by a State under this paragraph, the Secretary shall take into account—

(i) factors beyond the State's control (including disasters, strikes by State or other staff personnel engaged in determining eligibility or processing cases, sudden workload changes resulting from changes in Federal or State laws or regulations or from rapid caseload growth, and State actions resulting from incorrect policy interpretations by Federal officials);

(ii) factors relating to agency commitment, including demonstrated commitment by upper level State officials to the error reduction program under this subsection, the sufficiency and quality of operational systems designed to reduce errors, the use of effective systems and procedures for the statistical and program analysis of quality control and related data, and effective management and execution of the corrective action process;

(iii) the State's past performance with respect to erroneous payments, including past error rate levels and past error rate reduction efforts;

(iv) the cost effectiveness of error rate reduction, both in general and in the particular circumstances existing within the State; and

(v) such other factors as the Secretary may determine to be appropriate, as specified in regulations or as detailed by the State in its waiver request.

The Secretary's regulations shall specify the factors to be considered and the criteria to be used in assessing waiver requests under this paragraph, and shall indicate the relative weight or importance of

each of such factors and criteria in order to assist State in determining the appropriateness of proposed requests.

(D) Notwithstanding the preceding provisions of this paragraph, the Secretary shall in any case grant a waiver requested by a State under subparagraph (B) for any fiscal year if such State's corrective action plan submitted under paragraph (1)(A)(iv) or (1)(C), or a separate plan for the reduction of errors submitted by such State along with its waiver request, provides in detail for the expenditure of additional State and local funds for the reduction of errors in such fiscal year in a total amount (over and above the amount of State and local funds that would otherwise be expended in such fiscal year for the administration of the State plan approved under this part) equal to or exceeding one-half of the net amount of the disallowances that would otherwise be imposed with respect to such State under paragraph (2)(A) for such fiscal year. Expenditures of additional State and local funds for the reduction of errors as provided for in the corrective action plan or separate plan described in the preceding sentence shall be considered (for purposes of subsection (a)) to be expenditures for the proper and efficient administration of the State plan approved under this part.

(4)(A) Each State agency administering a plan approved under this part shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous payments made in connection with its administration of such plan, together with any other data which the Secretary may request that are reasonably necessary for the Secretary to carry out the provisions of this subsection.

(B) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through such contractual or other arrangements as the Secretary may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available and in accordance with such techniques for sampling and estimating as the Secretary may find appropriate.

(C) In any case in which it is necessary for the Secretary to exercise the authority under subparagraph (B) to determine a State's error rate for a fiscal year, the amount that would otherwise be payable to such State under this part for quarters in such year shall be reduced by the costs incurred by the Secretary in making such determination.

(5) For purposes of this subsection—

(A) the term "error rate," with respect to any State for any fiscal year, means the ratio of such State's erroneous payments for such year (as defined in subparagraph (B)) to its total payments under the State plan approved under this part for such year, determined (except as otherwise specifically provided) subject to the adjustments provided for in paragraph (2)(C); and

(B) the term "erroneous payments" means—

(i) payments to ineligible families receiving assistance, and

(ii) overpayments to eligible families receiving assistance.

(6) This subsection shall not apply with respect to Puerto Rico, Guam, or the Virgin Islands.

* * * * * * *

DEPENDENT CHILDREN OF UNEMPLOYED PARENTS

SEC. 407. (a) * * *

(b) [The provisions of subsection (a) shall be applicable to a State if the State's plan approved under section 402—] *In providing for the payment of aid under the State's plan approved under section 402 in the case of families which include dependent children within the meaning of subsection (a) of this section, as required by section 402(a)(40), the State's plan—*

(1) [requires] *shall require* the payment of aid to families with dependent children with respect to a dependent child as defined in subsection (a) when—

(A) whichever of such child's parents is the principal earner has not been employed (as determined in accordance with standards prescribed by the Secretary) for at least 30 days prior to the receipt of such aid,

(B) such parent has not without good cause, within such period (of not less than 30 days) as may be prescribed by the Secretary, refused a bona fide offer of employment or training for employment, and

(C)(i) such parent has 6 or more quarters of work (as defined in subsection (d)(1)) *, including 2 or more quarters of work as defined in subsection (d)(1)(A),* in any 13-calendar-quarter period ending within one year prior to the application for such aid or (ii) such parent received unemployment compensation under an unemployment compensation law of a State or of the United States, or such parent was qualified (within the meaning of subsection (d)(3)) for unemployment compensation under the unemployment compensation law of the State, within one year prior to the application for such aid; and

(2) [provides] *shall provide—*

(A) for such assurances as will satisfy the Secretary that unemployed parents of dependent children as defined in subsection (a) will be certified to the Secretary of Labor as provided in section 402(a)(19) within 30 days after receipt of aid with respect to such children;

(B) for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education in the State, designed to assure maximum utilization of available public vocational education services and facilities in the State in order to encourage the retraining of individuals capable of being retrained;

(C) for the denial of aid to families with dependent children to any child or relative specified in subsection (a)—

(i) if and for so long as such child's parent described in paragraph (1)(A), unless exempt under section 402(a)(19)(A), is not currently registered pursuant to such section for the work incentive program estab-

lished under part C of this title, or, if he is exempt under such section by reason of clause (iii) thereof or no such program in which he can effectively participate has been established or provided under section 432(a), is not registered with the public employment offices in the State, and

(ii) with respect to any week for which such child's parent described in paragraph (1)(A) qualifies for unemployment compensation under an unemployment compensation law of a State or of the United States, but refuses to apply for or accept such unemployment compensation; and

(D) for the reduction of the aid to families with dependent children otherwise payable to any child or relative specified in subsection (a) by the amount of any unemployment compensation that such child's parent described in paragraph (1)(A) receives under an unemployment compensation law of a State or of the United States.

* * * * * * *

(d) For purposes of this section—

(1) the term "quarter of work" with respect to any individual means a calendar quarter *(A)* in which such individual received earned income of not less than $50 (or which is a "quarter of coverage" as defined in section 213(a)(2)), or in which such individual participated in a community work experience program under section 409, or the work incentive program established under part C, *or (B) if the State plan so provides (but subject to the last sentence of this subsection), in which such individual (i) was in regular full-time attendance as a student at an elementary or secondary school, (ii) was in regular full-time attendance in a course of vocational or technical training designed to fit him or her for gainful employment, or (iii) participated in an education or training program established under the Job Training Partnership Act.*;

(2) the term "calendar quarter" means a period of 3 consecutive calendar months ending on March 31, June 30, September 30, or December 31;

(3) an individual shall, for purposes of section 407(b)(1)(C), be deemed qualified for unemployment compensation under the State's unemployment compensation law if—

(A) he would have been eligible to receive such unemployment compensation upon filing application, or

(B) he performed work not covered under such law and such work, if it had been covered, would (together with any covered work he performed) have made him eligible to receive such unemployment compensation upon filing application; and

(4) the phrase "whichever of such child's parents is the principal earner", in the case of any child, means whichever parent, in a home in which both parents of such child are living, earned the greater amount of income in the 24-month period the last month of which immediately precedes the month in which an application is filed for aid under this part

on the basis of the unemployment of a parent, for each consecutive month for which the family receives such aid on that basis.

No individual shall be credited during his or her lifetime (for purposes of subsection (b)(1)(C)(i)) with more than 4 "quarters of work" based on attendance in a course or courses of vocational or technical training as described in paragraph (1)(B)(ii) of this subsection.

* * * * * * *

GRANTS FOR PROGRAMS TO PREVENT TEENAGE PREGNANCIES AND TO ASSIST PREGNANT INDIVIDUALS AND TEENAGE PARENTS OF YOUNG CHILDREN IN ACHIEVING SELF-SUFFICIENCY

SEC. 416. (a)(1) For the purpose of assisting States and localities in establishing and carrying out programs—

(A) to reduce the rate of teenage pregnancies in AFDC families; and

(B) to help pregnant individuals and teenage parents of young children in such families, who might otherwise become long-term recipients of aid to families with dependent children, in achieving self-sufficiency,

there are authorized to be appropriated the sum of $50,000,000 for the fiscal year 1986 and the sum of $100,000,000 for the fiscal year 1987, to be used by the Secretary in making grants for such programs in accordance with this section. Any State which provides for the establishment and carrying out of one or more such programs in accordance with this section shall be entitled to receive a grant under this section for each such fiscal year, in an amount determined under subsection (d).

(2) The State agency administering or supervising the administration of the State's plan approved under section 402 shall be responsible for administering or supervising the administration of the State's programs described in paragraph (1) for which grants under this section are made. Such grants shall be made directly to the State agency, and may be—

(A) used by such agency for the purpose of conducting and providing in accordance with this section (directly or under contracts with others) the activities and services required to carry out the program or programs involved, or

(B) paid by such agency to local school districts or to other local agencies or public or private nonprofit entities meeting the requirements of this section, under arrangements made with such districts or (through such districts) with such other agencies and entities, for use by such districts, agencies, or entities in conducting and providing in accordance with this section (directly or under contracts with others) the activities and services required to carry out the program or programs involved;

but such grants may be used only in areas which are determined by the State agency to be areas of high teenage pregnancy or high infant mortality, and it must be the objective of any program for which such grants are used to carry out both the purpose described in subparagraph (A) of paragraph (1) and the purpose described in subparagraph (B) of such paragraph.

(3) In order to qualify for a grant under this section for any fiscal year with respect to a program or programs described in paragraph (1) in any State, the State agency must submit to the Secretary no later than 3 months after the beginning of such year, in such manner and form as the Secretary may prescribe, a full and complete description of the program together with satisfactory assurances that the program will be operated in an effective and efficient manner and will otherwise meet the requirements of this section.

(4) Grants made under this section—

(A) shall be in addition to any amounts payable to States under section 403, and shall supplement and not replace any other funds which may be available for the same general purposes, or for the provision of services of any kind to needy individuals, in the localities involved, and

(B) shall not be used to provide any individual with services which are available to that individual under a State plan approved under section 1902.

(b)(1) In carrying out the purpose described in subparagraph (A) of subsection (a)(1), it shall be the objective of each program under this section (subject to the availability of funds) to—

(A) conduct activities and provide services which may help to reduce pregnancies among children, targeting such activities and services to children who are eligible for aid to families with dependent children, in order to assure that such children will not be prevented from achieving self-sufficiency by parental responsibilities imposed upon them before they reach adulthood;

(B) identify and address all of the factors which may play important roles in determining teenage sexual activity and contraceptive use;

(C) encourage active participation by the parents of the children involved in the activities and services being conducted or provided under the program; and

(D) encourage the children involved to develop education and employment goals for the future, combining new and existing resources to assist such children in achieving those goals and encouraging such children to postpone sexual activity and child bearing and to assume responsibility for family planning in order to achieve them.

(2)(A) To the maximum extent appropriate and feasible, the activities conducted and services provided in carrying out the purpose described in subparagraph (A) of subsection (a)(1) shall include the services which are made available to pregnant individuals and teenage parents with young children under the program as more specifically described in subsection (c).

(B) None of the activities conducted or services provided under this subsection or subsection (c) as a part of any program under this section may include the performance of abortions, or include the counseling of individuals to have abortions except where the life of the mother would be endangered if the fetus were carried to term.

(c)(1) In carrying out the purpose described in subparagraph (B) of subsection (a)(1), it shall be the objective of each program under this section (subject to the availability of funds) to help achieve self-sufficiency for individuals under the age of 25 who are eligible for aid to families with dependent children, who (at the start of their par-

ticipation in the program) are pregnant or are teenage parents with children under the age of 6, and who voluntarily elect to participate in the program, by—

(A) requiring such individuals to seek a high school diploma or its equivalent or to take part in appropriate training,

(B) providing each participant with academic or vocational training, job counseling, employment readiness, and job placement services,

(C) integrating and coordinating services otherwise available to participants, and

(D) providing each participant with other services and assistance designed to meet such objective, including an individualized assessment and plan, as more particulary described in paragraph (3).

(2) Participation in program activities conducted and services provided with the objective specified in paragraph (1) shall be limited to individuals under the age of 25 residing within the area covered by the program who are pregnant, or who are teenage parents of dependent children under the age of 6, and shall include any such individual only if he or she (at the time of initial participation in the program)—

(A) has not graduated from high school or its equivalent, and

(B) voluntarily elects (subject to subsection (e)) to participate; and the funds made available under this section may be used only for activities and services so conducted or provided in the case of individuals (described in the preceding provisions of this paragraph) who are eligible under this part (individually or as members of families) for aid to families with dependent children under the State's plan approved under section 402, or whose children are eligible for such aid.

(3) A program described in subsection (a)(1) meets the requirements of this section only if the activities conducted and services provided with the objective specified in paragraph (1) include—

(A) provision for the assignment to each participant of an agency staff person who, utilizing the case management approach and in coordination with the participant, will establish an individualized program, based on an individualized assessment of need and set forth in an individualized written plan, to meet the health needs of the participant and his or her dependent (or unborn) child, and to ensure the provision and coordination (on behalf of such participant and child) of such other services as the state determines to be necessary or appropriate to carry out the objective of this section, including, at a minimum, academic and vocational services, health services, training in parenting skills, job counseling, emloyment readiness, job placement, transportation, and child day care;

(B) provision for the integration and coordination of services which are otherwise available at the local level to individuals under age 25 who are pregnant or are teenage parents with children under age 6 and which are offered under this part, under parts B and C of this title, under title V, under title XX, under the Job Training Partnership Act, and under other Federal and State programs that would assist in achieving the objectives of the program under this section;

(C) provision for the coordination (with the local school system) of academic and vocational programs leading to a high school diploma or its equivalent, with a requirement of active participation in an educational program leading to a high school diploma or its equivalent, or in an appropriate training program, as a condition of participation in the program under this section;

(D) provision for job counseling, training, employment readiness, and job placement and relevant supportive services independently or in conjunction with one or more programs of employment and training under this part or part C of this title, under the Job Training Partnership Act, or under another Federal or State law;

(E) provision of child care at the program site or of other child day care services which have been contracted for on a reimbursable basis, to the extent necessary for teenage parents to participate effectively in the program, with a requirement that such care and services meet applicable State and local standards and with emphasis upon services that are compatible with the goal of achieving self-sufficiency;

(F)(i) assurances that all such child care and services, and any transportation to and from work which may be necessary for a teenage parent or pregnant individual to participate effectively in the program, will be provided or arranged for without any charge to such parent or individual while he or she is participating in any phase or the program, and

(ii) assurances that such care, services, and transportation will be provided or arranged for on a sliding scale basis (with charges based on ability to pay) during at least the first 6 months of work after the teenage parent or pregnant individual has completed his or her participation in the program, in order to ensure a smooth transition into the workforce;

(G) provision for variations in the selection and offering of services to individual participants to the extent necessary to take account of differences in the needs of such participants and in their age, family composition, cultural background, and geographic location;

(H) assurances that, in order to encourage participants to take advantage of the full range of services offered, as many of such services as possible will be provided at a single site, with programs and activities being conducted in the local schools to the maximum extent feasible;

(I) provision for the establishment of peer groups of participants, led by experienced group counselors, to enable such participants to meet and discuss program-related problems and issues and to share their common concerns, and to serve as a medium for the communication and dissemination of relevant information; and

(J) provision for the establishment of an outreach program designed to attract pregnant individuals and teenage parents of young children who would be eligible to participate.

Program activities conducted and services provided with the objective specified in paragraph (1) must include but need not be limited to the services and assistance set forth in the preceding provisions of

this paragraph, and may include such other health, family planning, educational, training, and social services as may be needed to achieve such objective in cases where the necessary funding is not available from other sources.

(4) In the case of a teenage parent participating in program activities conducted or services provided with the objective specified in paragraph (1), absences from his or her child for the purpose of attending a secondary or post-secondary school or participating in other education or training activities as a part of the program shall not be considered 'absences from the child' in determining whether he or she is exempted under clause (v) of section 402(a)(19)(A) from the requirement of registration under that section.

(5) As used in this section, the term "teenage parent" means a male or female individual who is the parent of a child under the age of 6 and who (A) has not attained the age of 20 or (B) became the parent of such child before attaining the age of 20.

(d)(1) The grant to which any State is entitled from the sum appropriated pursuant to subsection (a)(1) for any fiscal year shall be in an amount bearing the same ratio to the sum so appropriated as the amount expended by such State during the preceding fiscal year as aid to families with dependent children under its plan approved under section 402 bears to the total amount expended by all the States during such preceding year as aid to families with dependent children under their plans so approved.

(2) If any State does not qualify for a grant under this section for any fiscal year within the time provided in subsection (a)(3), the amount of the grant to which it would have been entitled for such year shall be reallocated to one or more other States on the basis of their relative need for additional assistance under this section (as determined by the Secretary).

(e) If any State wishes to require participation in activities and services provided under subsection (c) by all individuals who are eligible to participate in such activities and services (or would be eligible to so participate if they satisifed paragraph (2)(B) of such subsection) and with respect to whose participation funds made available under this section may be used, such State may request that the Secretary waive the requirement of such paragraph (2)(B) and permit the State to make participation mandatory for all such individuals. The Secretary shall grant any such request and permit the State to require participation by all such individuals if he or she determines that—

(1) the funds available for the program from Federal, State, local, and other sources (including this section) are sufficient to conduct all of the activities and provide all of the services which would be necessary to serve such individuals; and

(2) mandatory participation in the program by all such individuals can be effectively administered and enforced by the State and the locality or localities involved.

(f)(1) Prior to expenditure by a State of any grant payments made to it under this section for any fiscal year, the State shall report to the Secretary on the intended use of such payments; and such report shall be revised from time to time throughout the fiscal year involved if and to the extent that there are significant changes in such use.

(2) No later than March 1, 1987, each State shall submit to the Secretary a full and complete report on the activities carried out with the proceeds of the grant or grants theretofore made to it under this section. The report—

(A) shall be in such form and contain such information as may be necessary to provide an accurate description of such activities, to provide a complete record of the purposes for which the grant funds were spent, to indicate the extent to which such funds were spent in a manner consistent with the report or reports submitted under paragraph (1), and to indicate the extent to which the expenditure of such funds succeeded in accomplishing the objectives for which the grant was made, and

(B) shall specifically contain such information as the Secretary may require in order to include in his or her evaluation under paragraph (3) the overall description referred to in subparagraph (B) thereof.

(3)(A) No later than July 1, 1987, the Secretary, on the basis of the reports submitted by a State under paragraphs (1) and (2) for the fiscal year 1986 and of such additional information as he or she may obtain or develop, shall evaluate the use by such State of the grant or grants made to it under this section for that year in the light of the purposes of this section, with the objective of appraising the achievements of the programs for which such grants were made and developing comprehensive information and data on the basis of which decisions can be made with respect to the improvement of such programs and the desirability of providing further assistance in subsequent years. The Secretary shall report such evaluation to the Congress.

(B) As a part of the evaluation under subparagraph (A) the Secretary shall include, at a minimum, a detailed overall description of the number and characteristics of the individuals served by the programs, the various kinds of activities conducted and services provided and the results achieved, and shall set forth in detail his or her findings and comments with respect to the various State programs and a statement of his or her plans and recommendations for the future.

(C) If as a result of the evaluation the Secretary determines that any such grant was used in a manner inconsistent with the purposes of this section or the objective stated in subparagrpah (A) or if the reports submitted by the State were insufficient to indicate whether or not the grant was so used, the Secretary shall notify the State of his or her disapproval, and the inconsistent use of such grant shall be subject to sanctions of the type described in section 404(a) as though this section were a part of the approved State plan as such inconsistent use were a failure to comply with a provision required by section 402(a) to be included in such plan.

(g) Grant payments to a State under this section for any fiscal year—

(1) shall be used only for the specific purposes described in this section;

(2) may be made on an estimated basis in advance of the determination of the exact grant amount, with appropriate subsequent adjustments to take account of any error in the estimates; and

(3) shall be expended by such State in that fiscal year or in the succeeding fiscal year.

(h) Notwithstanding any other provision of this title, payments made and services provided to participants in a program under this section, as a direct consequence of their participation in such program, shall not be considered as income or resources for purposes of determining their eligibility (or the eligibility of any other persons) for aid under the State's plan approved under section 402, or for purposes of determining the level of such aid.

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TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

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PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

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FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) Any utilization and quality control peer review organizations entering into a contract with the Secretary under this part must perform the following functions:

(1) * * *

* * * * * * *

(8) The organization shall perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carryout the provisions of this part or as may be required to carry out section 1862(a)(15).

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1181. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part of (1) invididuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain [Federal] *government* employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so

entitled to such benefits if certain [Federal] *government* employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

* * * * * * *

CONDITIONS OF ANY LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) * * *

* * * * * * *

Payment for Hospice Care

(i)(1)(A) * * *

[(B) Notwithstanding subparagraph (A), the rate of payment per day for routine home care furnished during fiscal year 1985 shall be $53.17.]

(B) Notwithstanding subparagraph (A) and for hospice care furnished on or after October 1, 1985, the daily rate of payment per day for routine home care shall be $63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by $10.

(C) With respect to care and services furnished on or after October 1, [1985,] *1986,* the Secretary shall, not less often than annually, review and make appropriate adjustments to the payment rate for routine home care and the payment rates for other services included in hospice care based on the costs that are reasonable and related to the costs of furnishing such care and services. The Secretary shall report to Congress on October 1 each year on such review and such adjustments and on the adequacy of the rates under this paragraph to ensure participation by an adequate number of hospice programs under this title.

* * * * * * *

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. (a) * * *

* * * * * * *

(c) The provisions of section 1837 (except subsection (f) thereof), section 1838, subsection (b) of section 1839, and subsections (f) and (h) of section 1840 shall apply to persons authorized to enroll under this section except that—

(1) * * *

* * * * * * *

(5) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 226

of this Act or section 103 of the Social Security Amendments of 1965; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement; [and]

(6) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this Act[.]*; and*

(7) any percent increase effected under section 1839(b) in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12-month periods described in that section.

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * * * *

[(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies;]

(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(g) In the case of services described in the [next to last] *Second* sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b). *In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year,*

no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).

* * * * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) * * *

* * * * * * *

(C) in the case of outpatient physical therapy services *or outpatient occupational therapy services,* (i) such services are or were required because the individual needed physical therapy services, *or occupational therapy services, respectively,* (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist *or qualified occupational therapist, respectively* providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

* * * * * * *

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g)),* or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g)),* but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. * * *

* * * * * * *

(i)(1) In the case of an individual who—

[(A) meets the conditions described in clauses (i) and (iii) of section 1862(b)(3)(A),]

(A) has attained the age of 65,

(B) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or the individual's spouse's) current employment, and

(C) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period,

there shall be a special enrollment period described in paragraph (3).

(2) In the case of an individual who—

[(A) meets the conditions described in clauses (i) and (iii) of section 1862(b)(3)(A),

[(B) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period and any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment, and]

(A) has attained the age of 65;

(B)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(B);

(C) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment; and

[(C)] *(D)* has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment,

there shall be a special enrollment period described in paragraph (3).

[(3) The special enrollment period referred to in paragraphs (1) and (2) is the period—

[(A) beginning with the first day of the third month before the month in which the individual attains the age of 70 and ending seven months later, or

[(B) beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later,

whichever period results in earlier coverage.]

(3) The special enrollment period referred to in paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later.

COVERAGE PERIOD

SEC. 1838. (a) * * *

* * * * * * *

[(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to—

[(1) subparagraph (A) of section 1837(i)(3)—

[(A) before the month in which he attains the age of 70, the coverage period shall begin on the first day of the month in which he has attained the age of 70, or

[(B) in or after the month in which he attains the age of 70, the coverage period shall begin on the first day of the month following the month in which he so enrolls; or

[(2) subparagraph (B) of section 1837(i)(3)—

[(A) in the first month of the special enrollment period, the coverage period shall begin on the first day of such month, or

[(B) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which he so enrolls.]

(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3)—

(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

AMOUNT OF PREMIUMS

SEC. 1839 (a)(1) * * *

* * * * * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) or (e) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account [months in which the individual has met the conditions specified in clauses (i) and (iii) of section 1862(b)(3)(A) and can demonstrate that the individual was enrolled in a group health plan described in clause (iv) of such section] *months during which the individual has attained that age of 65 and which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv)* by reason of the indivual's (or the individual's spouse's) current employment. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with re-

spect to any other continuous period of eligibility which such individual may have.

* * * * * * *

(e)(1) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January [1988] *1984* shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

(2) Any increases in premium amounts taking effect prior to January [1988] *1989* by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3).

(f)(1) If on cost-of-living increase becomes effective under section 215(i) in December of 1985 [or 1986], *1986, or 1987,* the monthly premium of each individual enrolled under this part for each month in the succeeding year shall (except as otherwise provided in subsection (b)) be the same as the monthly premium (disregarding subsecion (b)) of the individual for such December.

(2) If paragraph (1) does not apply to the monthly premiums for 1986 [or 1987], *1987 or 1988,* if an individual is entitled to monthly benefits under section 202 or 223 for November and for December in the preceding year, and if the monthly premium for the December and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 203 shall (except as otherwise provided in subsection (b)) be the greater of—

(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) necessary to make the monthly benefits under section 202 or 223 for that December after the deduction of the monthly premium (disregarding subsection (b)) for the January at least equal to the monthly benefits under section 202 or 223 for the preceding November after the deduction of the premium (disregarding subsection (b)) for that individual for the December, or

(B) the montly premium (disregarding subsection (b)) for that individual for the December.

For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *
(b)(1) * * *

* * * * * * *

(4)(A)*(i)* In determining the prevailing charge levels under the third and fouth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the

Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after October 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous fiscal year for physicians who were participating physicians during that year.

(B)*(i)* In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(C)*(i)* In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)*(i)* as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)*(i)*.

(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the periods beginning after September 30, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).

(D)*(i)* In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1985, or October 1, 1986, by a physician [who at no time for any services furnished during the 12-month period beginning October 1, 1984, was a participating physician (as defined in subsection (h)(1))] *who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985,* the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginning on July 1, 1984, above the level of the phy-

sician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1986, or October 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on September 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.

* * * * * * *

[The bill realigns the margins of subclause (7)(B)(ii) (III) and clause (7)(B)(iii) to conform to the margins of the other subclauses and clauses of the paragraph:]

(7)(A) * * *

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), the carrier shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicans, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greatest of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i),

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients, or

(III) 85 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in a hospital agree to have payment made for all of their physician's services under this part furnished to patients in such hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1870(f)(1), the customary charge for such services shall be equal to 90 percent of the prevailing charges paid for similar services in the same locality.

(8) The Secretary by regulation shall—

(A) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

(B) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.

(9) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

(A) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services, and

(B) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.

* * * * * * *

[The following new paragraphs (h)(4)–(h)(6) were formerly paragraphs (i)(2)–(i)(4):]

(h)(1) * * *

* * * * * * *

[2] *(4)* At the beginning of each fiscal year the Secretary shall publish a directory *directories (for appropriate local geographic areas)* containing the name, address, and specialty of all participating physicians and suppliers (as defined in [subsection [h](1)) *for that area* for that fiscal year. [The] *Each* directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part.

[3] *(5)* The Secretary shall promptly notify individuals enrolled under this part of the publication of [such list and directory] *the directories* and shall make [such list and directory] *the appropriate area directory or directories* available in each district and branch office of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.

[4] *(6)* The Secretary shall provide that [the list and directory] *the directories* shall be available for purchase by the public. *The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area.*

(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis, described in paragraph (8)), shall include—

(A) a reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers), and

(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers.

(8) For purposes of this title, a claim is considered to be paid on an "assignment-related basis" if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).

[(i)(1) Each year the Secretary shall publish a list containing the name, address, specialty, and percent of claims submitted with respect to each physician and supplier during the preceding year that were paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1). The Secretary may limit such list to those physicians and suppliers who accepted such an assignment in a certain percentage of such physician's or supplier's billings or who provide at least a certain volume of services, as the Secretary may determine to be appropriate. Such list shall be organized by such geographical area as the Secretary determines, after consultation with carriers, would facilitate the use of such list be individuals enrolled under this part.]

(j)(1) [In the case of a physician who is not a participating physician, the Secretary shall monitor each such physician's actual charges to individuals enrolled under this part for physicians' services funished during the 15-month period beginning July 1, 1984.] *In the case of a physician who is not a participating physician for items and services furnished during a portion of the 27-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period.* If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under paragraph (1) *or subsection (l)* are—

(A) barring a physician from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d), or

(B) the imposition of civil monetary penalties and assessments, in the same manner as such penalties are authorized under section 1128A(a),

or both. No payment may be made under this title with respect to any item or service furnished by a physician during the period when he is barred from participation in the program under this title pursuant to this subsection.

(k)(l) In determining the customary and prevailing charge levels under the third and fourth sentences of subsection (b)(3) for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) during the 12-month period beginning on October 1, 1985, the Secretary shall not set any such level higher than 101 percent of the same level as was set for the 15-month perod beginning July 1, 1984.

(2) Payment under this part for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) may only be made on an assignment-related basis (as defined in subsection (h)(8)) or to a provider of services with an agreement in effect under section 1866.

(3) In the case of durable medical equipment, the prevailing charge levels determined for purposes of clause (ii) of the third sen-

tence of subsection (b) for any 12-month period (beginning after September 30, 1986) may not exceed (in the aggregate) the levels determined under such clause (taking into account paragraph (1), if applicable) for the preceding 12-month period by a percentage which exceeds the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average), as published by the Secretary of Labor, for the 12-month period ending in March of that preceding 12-month period.

(l)(1) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(2) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

* * * * * * *

STUDY OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES

SEC. 1845. (a) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part.

(b) In developing the scale, the Secretary shall consider among other items—

(1) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984,

(2) the recommendations of the Prospective Payment Assessment Commission under section 1886(e)(7)(C), and

(3) factors with respect to the input costs for furnishing particular physicians' services, such as—

(A) the differences in costs of furnishing services in different settings,

(B) the differences in skill levels and training required to perform the services, and

(C) the time required, and risk involved, in furnishing different services.

(c) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than April 1, 1987. The report shall include recommendations for the application of the scale to the payment for physicians' services furnished under this part on or after October 1, 1987.

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational therapy" shall be substituted for "physical therapy" each place it appears therein.

* * * * * * *

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used **[**as**]** *at* his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased.

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(D) outpatient physical therapy services *and outpatient occupational therapy services;*

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any **[**fiscal**]** *cost reporting* period shall **[**not exceed one and one half times**]** *be equal to* the average of the rates of interest, for each of the months any part of which is

included in [such fiscal] *the* period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) *on the basis of* the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * * * *

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital or skilled nursing facility which has undergone a change of ownership, such regulations shall provide, *except as provided in clause (iv),* that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of the date of the enactment of this subparagraph (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

* * * * * * *

(iv) In the case of the transfer of a hospital or skilled nursing facility from ownership by a State to ownership by a non-profit corporation without monetary consideration, clause (i) shall be applied without regard to the acquisition cost of the hospital or facility to the new owner.

(P)(i) Such regulations may not provide for any payment, with respect to the reasonable costs of inpatient hospital services, for a return on equity capital for hospitals.

(ii) If such regulations provide for the payment for a return on equity capital, the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

* * * * * * *

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of section 1861(p) *(including through the operation of section 1861(g))* the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

* * * * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * * * *

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care); [or]

(14 which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph) and which are furnished to an individual who is an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital[.]; *or*

(15) which are for services of an assistant at surgery in a cataract operation unless, before the surgery is performed, the appropriate utilization and quality control peer review organiza-

tion (under part B of title XI) has approved of the use of such an assistant in the surgical procedure based on the existence of complicating medical condition.

(b)(1) * * *

* * * * * * *

(3)(A)(i) Payment under this title may not be made, except as provided in clause (ii), with respect to any item or service furnished in any month during the period described in clause (iii) to an individual [who is under 70 years of age during any part of such month] (or to the spouse of such individual [, if the spouse is under 70 years of age during any part of such month]) who is employed at the time such item or service is furnished to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made, under a group health plan (as defined in clause (iv)) under which such individual is covered by reason of such employment.

* * * * * * *

(iii) The provisions of clauses (i) and (ii) shall apply to an individual only for the period beginning with the month in which such individual becomes entitled to benefits under this title under section 226(a) [and ending with the month before the month in which such individual attains the age of 70] and shall not include any month for which the individual would, upon application, be entitled to benefits under section 226A.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2), [and]

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital[.], *and*

(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable.

* * * * * * *

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g)),* or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g)),* but only with respect to the furnishing of outpatient physical therapy services (as therein defined) *or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * * * *

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTING LABOR

SEC. 1867. (a) MEDICAL SCREENING REQUIREMENT.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—If any individual (whether or not eligible for benefits under this title) comes to the hospital and the individual is determined (through the screening described in subsection (a) or otherwise) to have an emergency medical condition or to be in active labor, the hospital must provide either—

(1) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, unless the examination or treatment is refused, or

(2) for transfer of the patient to another medical facility in accordance with subsection (c).

(c) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.—

(1) RULE.—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

(A) there has been a written determination by a physician (within the meaning of section 1861(r)(1)) that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the benefits obtained from the provision of appropriate medical treatment

at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer, and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

(2) APPROPRIATE TRANSFER.—An appropriate transfer to a medical facility is a transfer—

(A) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the patient,

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment, and

(iii) is being provided appropriate medical records (or copies thereof) of the examination and treatment affected at the transferring facility,

(B) in which the transfer is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures during the transfer; and

(C) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patient transferred.

(d) ENFORCEMENT.—

(1) AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.—Failure of a hospital to meet the requirements of this section subjects the hospital to termination of its medicare provider agreement under this title, in accordance with section 1866(b).

(2) CIVIL MONETARY PENALTIES.—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section is subject, under that section, to a civil money penalty of not more than $25,000 for each such violation.

(3) CIVIL ENFORCEMENT.—Any person or entity that is adversely affected directly by a participating hospital's violation of a requirement of this section may bring an appropriate action, in an appropriate court of general jurisdiction of the State in which the hospital is located or in the appropriate Federal district court, for damages to the person arising from the violation and for such other equitable relief as may be appropriate to remedy the violation or deter subsequent violations.

(4) CRIMINAL PENALTIES.—

(A) IN GENERAL.—A responsible physician (as defined in subparagraph (B)) who—

(i) has professional responsibilities for the provision of a screening examination of a patient in the hospital's emergency department and either (I) knowingly fails to provide for any screening examination required under subsection (a) if the failure represents a gross deviation from the prevailing local standards of medical practice, or (II) provides for such a screening examination which is conducted in a manner that is so inappropriate as to represent a gross deviation from the prevailing local standards of medical practice, or

(ii) has professional responsibilities for the treatment of a patient, knows (or has reason to know) that the patient has an emergency medical condition or is in active labor, and who, within the staff and facilities available at the hospital, either (I) knowingly fails to carry out the individual's responsibilities to provide for treatment of the patient under subsection (b) if the failure represents a gross deviation from the prevailing local standards of medical practice, or (II) provides for such treatment in a manner that is so inappropriate as to represent a gross deviation from the prevailing local standards of medical practice, or

(iii) has professional responsibilities for the treatment of a patient, knows (or has reason to know) that either the patient has an emergency medical condition which has not been stabilized or the patient is in active labor, and either—

(I) knowingly transfers (or orders the transfer) of the patient other than to another medical facility, or

(II) knowingly transfers (or orders the transfer) of the patient to another medical facility, if the physician knows (or has reason to know) that the other facility does not have space available for the treatment of the patient and has not agreed to accept the patient,

shall be fined not more than $100,000 or imprisoned not more than one year, or both; except that, if, as a direct result of the violation of this paragraph, the patient dies, the physician shall be fined not more than $250,000 or imprisoned not more than five years, or both.

(B) RESPONSIBLE PHYSICIAN DEFINED.—As used in subparagraph (A), the term "responsible physician" means, with respect to a patient, a physician who—

(i) is employed by, or under contract with, a participating hospital, and

(ii) acting as such as employee or under such a contract, has professional responsibilities for the provision of examinations or treatments for the patient or transfers of the patient.

(e) DEFINITIONS.—In this section:

(1) The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term "active labor" means labor at a time at which—

(A) delivery is iminent,

(B) there is inadequate time to effect safe transfer to another hospital, or

(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

(3) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

(4)(A) The term "to stabilize" means, with respect to a medical condition, to provide such medical treatment of the condition as may be necessary to assure that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term "stabilized" means, with respect to a medical condition, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) PREEMPTION.—The provision of this section do not preempt any State or local law requirement respecting hospitals, except to the extent that the requirement directly conflicts with a requirement of this section.

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) The Secretary shall annually determine, *and shall publish not later than September 7 before the calendar year concerned—*

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).

* * * * * * *

(3) [Payments] *Subject to subsection (c)(7), payments* under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and

1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

* * * * * * *

(6) [If] *Subject to subsection (c)(7), if* an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

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(c)(1) * * *

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(3)(A)(i) * * *

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(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following [a full calendar month after] *the date on which* the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. *In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.*

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. *No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.*

* * * * * * *

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1886(d), and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) * * *

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(b)(1) * * *

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(3)(A) * * *

(B) For purposes of subparagraph (A) and subsection (d) and except as provided in subsection (e), the "applicable percentage increase" for any 12-month cost reporting period or fiscal year shall be equal to one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year. [In determining a percentage change under subsection (e)(4) with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after October 1, 1985, and before October 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.] *Notwithstanding the previous sentence or subsection (e), for purposes of subparagraph (A) for cost reporting periods beginning during fiscal year 1986 and for purposes of subsection*

(d)(3)(A) for discharges occurring during that fiscal year, the applicable percentage increase shall be one percent.

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(c)(1) * * *

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(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a "36-month period" is deemed a reference to as "48-month period", and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating cost of inpatient hospital services (as defined in subsection (a)(4)) of subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, [1986,] *1987,* is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after October 1, [1986,] *1987,* is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges.

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1861(f)),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age, or

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary).

(C) For purposes of this subsection, for cost reporting periods beginning, or discharges occurring—

(i) on or after October 1, 1983, and before October 1, 1984, the "target percentage" is 75 percent and the "DRG percentage" is 25 percent;

(ii) on or after October 1, 1984, and before October 1, [1985,] *1986,* the "target percentage" is 50 percent and the "DRG percentage is 50 percent; and

(iii) on or after October 1, [1985,] *1986,* and before October 1, [1986,] *1987,* the "target percentage" is 25 percent and the "DRG percentage is 75 percent; and

(D) for purposes of subparagraph (A)(ii)(II), the "applicable combined adjusted DRG prospective payment rate" for cost reporting periods beginning, or discharges occurring—

(i) on or after October 1, 1984, and before October 1, [1985,] *1986,* is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, [1985,] *1986,* and before October 1, [1986,] *1987,* is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.— * * *

* * * * * * *

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs *(taking into account, for discharges occurring after September 30, 1985, the amendments made by section 104(a) of the Medicare Budget Reconciliation Amendments of 1985),*

(ii) adjusting for variations among hospitals by area in the average hospital wage level,[and]

(iii) adjusting for variations in case mix among hospitals[.], *and*

(iv) for discharges occurring during fiscal years 1986 and 1987, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F).

* * * * * * *

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payments may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased [for fiscal year 1985] *for each of fiscal years 1985 and 1986* by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

* * * * * * *

(C) *(i)* MAINTAINING BUDGET NEUTRALITY *FOR FISCAL YEAR 1985.*—[The] *For discharges occurring in fiscal year 1985, the* Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR SUBSEQUENT FISCAL YEARS.—For discharges occurring after fiscal year 1985, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization affected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring during—

(I) each of fiscal years 1986 and 1987, of an amount equal to the estimated reduction in the additional payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 104 of the Medicare Budget Reconciliation Amendments of 1985 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for each respective fiscal year instead of the factor described in clause (ii)(I) of that paragraph, and

(II) each fiscal year thereafter, of an amount equal to the estimated reduction in the additional payment amounts under paragraph (4)(B) for that fiscal year that has resulted from the enactment of the amendments made by section

104 of the Medicare Budget Reconciliation Amendments of 1985.

(D) COMPUTING DRG-SPECIFIC RATES FOR URBAN AND RURAL HOSPITALS.—For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted *or reduced* under subparagraph (C)) for the fiscal year for hospitals located in an urban area in the United States or that region, and

* * * * * * *

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted *or reduced* under subparagraph (C)) for the fiscal year for hospitals located in a rural area in the United States or that region, and

* * * * * * *

(5)(A)(i) * * *

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(B)*(i)* The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except that *for discharges occuring during fiscal years 1984 and 1985* in the computation under this subparagraph the Secretary shall use an educational adjustment factor equal to twice the factor provided under such regulations, *and except that for discharges for fiscal years after fiscal year 1985 the payment amount shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).* In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(ii) For purposes clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

(I) during fiscal years 1986 and 1987, is equal to 2 x $[(1+r)^{\circ}-1]$*, where "r" is the ratio of the hospital's full-time equivalent interns and residents (including those assigned to outpatient departments of the hospital) to beds and "°" is .405, or*

(II) after fiscal year 1987, is equal to 1.5 x [(1+r)°−1], where "r" is the same as "r" under subclause (I) and "°" is .5795.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas), and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title. A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region *and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center.* Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

* * * * * * *

(F)(i) The Secretary shall provide under this subparagraph, for discharges occurring during fiscal years 1986 and 1987, for an additional payment amount, for discharges occurring in a cost reporting period of a hospital, for a subsection (d) hospital that is located in an urban area, that has 100 or more beds, and that—

(I) serves a significantly disproportionate number of patients who have low income (as defined in clause (iv)(I)), or

(II) can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX) during the cost reporting period for indigent care from State and local government sources exceed 30 percent of its total of such revenues during the period.

(ii) The amount of such payment for each discharge shall be the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) for that discharge multiplied by the disproportionate share adjustment percentage established under clause (iii) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period—

(I) for a hospital described in clause (i)(II) is equal to 16 percent, and

(II) for other hospitals is equal to seven-tenths of the excess low income patient percentage (as defined in clause (iv)(IV) for that period,

but in no case may the percentage for any hospital for any period exceed 16 percent.

(iv) In this subparagraph:

(I) A hospital "serves a significantly disproportionate number of patients who have low income" for a cost reporting period if the hospital has a low income patient percentage (as defined in subclause (II)) for that period which equals, or exceeds, 15 percent.

(II) The term "low income patient percentage" means, with respect to a cost reporting period of a hospital, the percentage of its total number of patient days of inpatient hospital services it provided during periods which are attributable to low income patients (as defined in subclause (III)).

(III) The term "low income patient" means, with respect to inpatient hospital services provided to a patient, a patient who was, or is determined to have been, entitled to medical assistance under title XIX with respect to some or all of such services during the hospital stay, and includes such an individual notwithstanding the fact that some or all of such services were actually paid for under this title.

(IV) The term "excess low income patient percentage" means, for a cost reporting of a hospital, the hospital's low income patient percentage (as defined in subclause (II)) for that period minus 15 percent.

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(e)(1)(A)* * *

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(4) Taking into consideration the recommendations of the Commission, the Secretary shall determine for each fiscal year (beginning with fiscal year [1986,] *1987* the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

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[(6)(A) The Commission shall consist of 15 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members expire in any one year.]

(A)(i) The Commission shall consist of 23 members. Fifteen members of the Commission shall first be appointed no later than April 1, 1984, and the remaining members shall first be appointed no

later than January 1, 1986, for a term of three years, except that the Director may provide for such shorter terms as will insure that (on a continuing basis) the terms of no more than eight members expire in any one year. The Director shall appoint a member to serve as Chairman.

(ii) The Chairman of the Commission shall provide for two subcommittees of the Commission, one with functions and responsibilities relating primarily to hospital payment issues and the other with functions and responsibilities relating primarily to physician payment issues. The Chairman may assign members of the Commission to serve on either or both subcommittees of the Commission.

(B) The membership of the Commission shall provide expertise and experience in the provision and financing of health care, including physicians and registered professional nurses, employers, third party payors, *representatives of consumer and elderly groups,* individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals have expertise in the research and development of technological and scientific advances in health care. The Director shall seek nominations from a wide range of groups, including—

(i) national organizations representing physicians, including medical specialty organizations and registered professional nurses and other skilled health professionals;

(ii) national organizations representing hospitals, including teaching hospitals;

(iii) national organizations representing manufactures of health care products; and

(iv) national organizations representing the business community, health benefit programs, labor, and the elderly.

(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed **[**25**]** *35*) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

* * * * * * *

(I)(i) There are authorized be appropriated such sums as may be necessary to carry out the provisions of this paragraph.

(ii) **[**Eighty-five**]** *Fifty* percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and **[**15**]** *50* percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

* * * * * * *

(7)(A) The Commission shall make recommendations to the Congress, not later than February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making

payment, for physicians' services under this title and other items and services under part B.

(B) In making its recommendations, the Commission shall—

(i) consider, and make recommendations on the feasibility and desirability of reducing, the differences in payment amounts for physicians' services under part B which are based on differences in geographic location or specialty;

(ii) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

(iii) identify those charges recognized as reasonable under section 1842(b) which are significantly out-of-line, based on the considerations of clauses (i) and (ii);

(iv) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

(v) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under part B on an assignment-related basis;

(vi) make recommendations respecting the advisability and feasibility of making changes in the payment system for physicians' services under part B based on (I) the Secretary's study under section 603(b)(2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to hospital inpatients on the basis of diagnosis-related groups) and (II) the Office's report under section 2309 of the Deficit Reduction Act of 1984 (relating to physician reimbursement under part B);

(vii) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title; and

(viii) identify those procedures for which an opinion of a second physician should be required before payment is made under section 1845.

(C) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under paragraph (8).

* * * * * * *

(g)[1] If the Congress does not enact legislation, after the date of the enactment of this subsection and before October 1, 1986, respecting the payment under this title for capital-related costs for inpatient hospital services, no payment may be made under this title for capital-related costs of capital expenditures (as defined in section 1122(g) and except as provided in section 1122(j) for inpatient hospital services in a State, which expenditures are obligated after September 30, 1986, unless the State has an agreement with the Secretary under section 1122(b) and under the agreement the State has recommended approval of the capital expenditures.

[(2) The Secretary shall provide that the amount which is allowable with respect to reasonable costs of inpatient hospital services for which payment may be made under this title, for a return on equity capital for hospitals shall, for cost reporting periods begin-

ning on or after the date of the enactment of this subsection, be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.]

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PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

(b) With respect to a hospital Based skilled nursing facility, the Secretary shall recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilties attributable to excess overhead allocations (as determined by the Secretary) resulting from the reimbursement principles under this title, [nothwithstanding] *notwithstanding* the limits set forth in paragraph (3) or (4) of subsection (a).

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DEFICIT REDUCTION ACT OF 1984

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DIVISION B—SPENDING REDUCTION ACT OF 1984

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TITLE III—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH AMENDMENTS

* * * * * * *

Subtitle A—Medicare amendments

PART I— REIMBURSEMENT AND BENEFIT CHANGES

* * * * * * *

SEC. 2306. (a) * * *

(b)(1) Section 1842(b)(3) of such Act is amended—

(A) in subparagraph (F), by striking out "June 30" and inserting in lieu thereof "September 30";

(B) by striking out "July 1" each place it appears in the third and eighth sentences and inserting in lieu thereof in each instance "October 1"; and

(C) in the third sentence thereof, by striking out "during the last preceding calendar year elapsing prior to" and inserting in lieu thereof "during the 12-month period ending on the March 31 last preceding".

(2) The amendments made by paragraph (1) shall apply to items and services furnished on or after October 1, 1985 *and to durable medical equipment furnished on or after July 1, 1985.*

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(e) In addition to any funds otherwise provided for fiscal years 1984 [and 1985], *1985, and 1986* for payment to carriers under contracts entered into under section 1842 of the Social Security Act, there are transferred from the Federal Supplementary Medical Insurance Trust Fund, for payments to such carriers under such contracts to implement [the amendments made by this section,] *subsections (b)(4), (h), and (j) of section 1842 of the Social Security Act,* not less than $8,000,000 for fiscal year 1984, and not less than $15,000,000 [for fiscal year 1985.] *for each of fiscal years 1985 and 1986. A significant proportion of such funds shall be used for the expansion of the participating physician and supplier program and for the development of professional relations staffs dedicated to addressing the billing and other problems of physicians and suppliers participating in that program.*

* * * * * * *

PROSPECTIVE PAYMENT WAGE INDEX

SEC. 2316. (a) The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study to develop an appropriate index for purposes of adjusting payment amounts under section 1886(d) of the Social Security Act to reflect area differences in average hospital wage levels, as required under paragraphs (2)(H) and (3)(E) of such section, taking into account wage differences of full time and part time workers. The Secretary of Health and Human Services shall report the results of such study to the Congress not later than 30 days after the date of the enactment of this Act, including any changes which the Secretary determines to be necessary to provide for an appropriate index.

[(b) The Secretary shall adjust the payment amounts for hospitals for cost reporting periods beginning on or after October 1, 1983, to reflect any changes made in the wage index pursuant to subsection (a). Any adjustment in such payments to take account of overpayments or underpayments for the first cost reporting period of a hospital to which section 1886(d) of the Social Security Act applies, shall be made by decreasing or increasing payments in the succeeding cost reporting period.]

(b) The Secretary shall adjust the payment amounts for hospitals for discharges occurring during fiscal year 1986 to reflect the changes the Secretary has proposed (in the Federal Register on June 10, 1985) in regulations respecting the hospital wage index under section 1886(d)(3)(E) of the Social Security Act, as that proposal relates to the use of total gross hospital wages. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage differences of full-time and part-time workers.

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TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

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TITLE I—PROVISIONS RELATING TO SAVINGS IN HEALTH AND INCOME SECURITY PROGRAMS

Subtitle A—Medicare

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PART II—CHANGES IN BENEFITS, PREMIUMS, AND ENROLLMENT

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HOSPICE CARE

SEC. 122. (a)(1) * * *

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(h)(1)[(A) Subject to subparagraph (B), the] *The* amendments made by this section apply to hospice care provided on or after November 1, 1983[, and before October 1, 1986.].

[(B) An individual who on October 1, 1986, has an election under section 1812(d)(1) of the Social Security Act in effect for a period, is entitled to hospice care benefits after that date during the remainder of that period and any consecutive period to which the individual would have been entitled before such date.]

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TITLE II—REVENUE MEASURES

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SUBTITLE F—EXCISE TAXES

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PART III—CIGARETTES

SEC. 283. INCREASE IN TAX ON CIGARETTES.

(a) RATE OF TAX.—Subsection (b) of section 5701 (relating to rate of tax on cigarettes) is amended—

(1) by striking out "$4" in paragrpah (1) and inserting in lieu thereof "$8"; and

(2) by striking out "$8.40" in paragraph (2) and inserting in lieu thereof "$16.80".

(b) FLOOR STOCKS.—

(1) IMPOSITION OF TAX.—On cigarettes manufactured in or imported into the United States which are removed before January 1, 1983, and held on such date for sale by any person, there shall be imposed the following taxes:

(A) SMALL CIGARETTES.—On cigarettes, weighting not more than 3 pounds per thousand, $4 per thousand;

(B) LARGE CIGARETTES.—On cigarettes, weighing more than 3 pounds per thousand, $8.40 per thousand; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette.

(2) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on January 1, 1983, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be treated as a tax imposed under section 5701 and shall be due and payable on January 18, 1983 in the same manner as the tax imposed under such section is payable with respect to cigarettes removed on January 18, 1983.

(3) CIGARETTE.—For purposes of this subsection, the term "cigarette" shall have the meaning given to such term by subsection (b) of section 5702 of the Internal Revenue Code of 1954.

(4) EXCEPTION FOR RETAILERS.—The taxes imposed by paragraph (1) shall not apply to cigarettes in retail stocks held on January 1, 1983, at the place where intended to be sold at retail.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to cigarettes removed after December 31, 1982 [and before October 1, 1985.].

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INTERNAL REVENUE CODE OF 1954

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter B—Computation of Taxable Income

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PART II—ITEMS SPECIFICALLY INCLUDED IN GROSS INCOME

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SEC. 86. SOCIAL SECURITY AND TIER 1 RAILROAD RETIREMENT BENEFITS.

(a) IN GENERAL.—Gross income for the taxable year of any taxpayer described in subsection (b) (notwithstanding section 207 of the Social Security Act) includes social security benefits in an amount equal to the lesser of—

(1) one-half of the social security benefits received during the taxable year, or

(2) one-half of the excess described in subsection (b)(1).

(b) TAXPAYERS TO WHOM SUBSECTION (a) APPLIES.—

(1) IN GENERAL.—A taxpayer is described in this subsection if—

(A) the sum of—

(i) the modified adjusted gross income of the taxpayer for the taxable year, plus

(ii) one-half of the social security benefits received during the taxable year, exceeds

(B) the base amount.

(2) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, the term "modified adjusted gross income" means adjusted gross income—

(A) determined without regard to this section and sections 221, 911, 931, and 933, and

(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(c) BASE AMOUNT.—For purposes of this section, the term "base amount" means—

(1) except as otherwise provided in this subsection, $25,000,

(2) $32,000, in the case of a joint return, and

(3) zero, in the case of a taxpayer who—

(A) is married at the close of the taxable year (within the meaning of section 143) but does not file a joint return for such year, and

(B) does not live apart from his spouse at all times during the taxable year.

(d) SOCIAL SECURITY BENEFIT.—

(1) IN GENERAL.—For purposes of this section, the term "social security benefit" means any amount received by the taxpayer by reason of entitlement to—

(A) a monthly benefit under title II of the Social Security Act, or

(B) a tier 1 railroad retirement benefit.

For purposes of the preceding sentence, the amont received by any taxpayer shall be determined as if the Social Security Act did not contain section 203(i) thereof.

(2) ADJUSTMENT FOR REPAYMENT DURING YEAR.—

(A) IN GENERAL.—For purposes of this section, the amount of social security benefits received during any taxable year shall be reduced by any repayment made by the taxpayer during the taxable year of a social security benefit previously received by the taxpayer (whether or not such benefit was received during the taxable year).

(B) DENIAL OF DEDUCTION.—If (but for this subparagraph) any portion of the repayments referred to in subparagraph (A) would have been allowable as a deduction for the taxable year under section 165, such portion shall be allowable as a deduction only to the extent it exceeds the social security benefits received by the taxpayer during the taxable year (and not repaid during such taxable year).

(3) WORKMEN'S COMPENSATION BENEFITS SUBSTITUTED FOR SOCIAL SECURITY BENEFITS.—For purposes of this section, if, by

reason of section 224 of the Social Security Act (or by reason of section 3(a)(1) of the Railroad Retirement Act of 1974), any social security benefit is reduced by reason of the receipt of a benefit under a workmen's compensation act, the term "social security benefit" includes that portion of such benefit received under the workmen's compensation act which equals such reduction.

[(4) TIER 1 RAILROAD RETIREMENT BENEFIT.—For purposes of paragraph (1), the term "tier 1 railroad retirement benefit" means a monthly benefit under section 3(a), 3(f)(3), 4(a), or 4(f) of the Railroad Retirement Act of 1974.]

(4) TIER 1 RAILROAD RETIREMENT BENEFIT.—For purposes of paragraph (1), the term "tier 1 railroad retirement benefit" means—

(A) the amount of the annuity under the Railroad Retirement Act of 1974 equal to the amount of the benefit to which the taxpayer would have been entitled under the Social Security Act if all of the service after December 31, 1936, of the employee (on whose employment record the annuity is being paid) had been included in the term employment as defined in the Social Security Act, and

(B) a monthly annuity amount under section 3(f)(3) of the Railroad Retirement Act of 1974.

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PART VI—ITEMIZED DEDUCTIONS FOR INDIVIDUALS AND CORPORATIONS

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SEC. 162. TRADE OR BUSINESS EXPENSES.

(a) IN GENERAL.—* * *

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(i) GROUP HEALTH PLANS.—

(1) [GENERAL RULE] *COVERAGE RELATING TO END STAGE RENAL DISEASE.*—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section if the plan differentiates in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner.

(2) CONTINUATION COVERAGE.—

(A) REQUIRING OPTION OF CONTINUATION COVERAGE WHEN QUALIFIED BENEFICIARY WOULD LOSE COVERAGE.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless each qualified beneficiary who would lose coverage under the plan because of a qualifying event is given, in accordance with this paragraph, the option of electing continuation coverage under the plan.

(B) ELECTION.—

(i) ELECTION PERIOD.—The option of electing continuation coverage must be offered during a period that—

(I) begins not later than the termination date (as defined in subparagraph (C)(ii)),

(II) is of at least 60 days duration, and

(III) ends not earlier than 60 days after the date the qualified beneficiary is notified under subparagraph (F)(iv) or the termination date, whichever date is later.

(ii) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Unless othewise specified in the election, any such election by a qualified beneficiary described in subparagraph (G)(ii)(I) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary whose coverage would, but for continuation coverage provided in accordance with this paragraph, be affected by the qualifying event.

(C) QUALIFYING EVENT AND TERMINATION DATE.—For purposes of this paragraph—

(i) A "qualifying event" under a group health plan, with respect to a covered employee, is any of the following events if coverage of a qualified beneficiary under the plan would, but for continuation coverage provided in compliance with this paragraph, be terminated by the occurrence of the event:

(I) The death of the covered employee.

(II) The divorce or separation of the covered employee from the employee's spouse.

(III) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

(ii) The term "termination date" means, with respect to a qualifying event, the date on which coverage of a qualified beneficiary under a group health plan but for continuation coverage provided in compliance with this paragraph.

(D) TERMS OF CONTINUATION COVERAGE.—Any continuation coverage elected by or on behalf of a qualified beneficiary shall meet the following requirements:

(i) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(ii) CONTINUED BENEFITS.—The coverage shall consist of coverage which is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

(iii) PERIOD OF CONTINUED COVERAGE.—The coverage shall be for a period commencing upon the termination date and ending not earlier than the earliest of the following:

(I) MAXIMUM OF FIVE YEARS.—Five years after the termination date.

(II) END OF PLAN.—The date on which the employer ceases to provide any group health plan to employees.

(III) FAILURE TO PAY PREMIUMS.—The date on which there is a failure in making timely payment of any premium required under the plan with respect to the qualified beneficiary.

(IV) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes or could become, after the date of the election, a covered employee under any other group health plan or becomes entitled to benefits under title XVIII of the Social Security Act.

(V) REMARRIAGE OF SPOUSE.—In the case of a qualified beneficiary described in subparagraph (G)(ii)(I), th date on which the beneficiary remarries and becomes (or could become) covered under a group health plan as the spouse of a covered employee.

(VI) CHILD TURNING MAJORITY.—In the case of any individual who is a qualified beneficiary by reason of having been a covered dependent child of a covered employec, the date on which the individual ceases to be a covered dependent child of the covered employee.

(iv) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continued coverage expires under clause (iii)(I), the plan must provide to the beneficiary, during the 180-day period ending on the date of expiration of the period of continued coverage, the option of enrollment under a conversion health plan otherwise generally available to beneficiaries under the plan.

(E) PREMIUMS FOR CONTINUATION COVERAGE.—

(i) AMOUNT.—The total premium charged by a group health plan with respect to any qualified beneficiary for continuation coverage under the plan shall not exceed the sum of employer premiums and employee permiums generally charged with respect to coverage under the plan of similarly situated beneficiaries with respect to whom a qualifying event has not occurred. The total of all premiums charged by the plan in any plan year may be based upon reasonably anticipated community costs for such plan year of the entire pool of covered employees and other beneficiaries under the plan, including qualified beneficiaries receiving continuation coverage under the plan under this paragraph.

(ii) PAYMENTS.—The plan may provide for payment of the total premium by the qualified beneficiary receiving such coverage, or for payment of all or part of such premium by the employer or other party and payment of the remainder of such premium by such beneficiary. The plan shall provide for payment of any premium by a qualified beneficiary in monthly installments if so elected by the beneficiary. If an election is made during an election period but after the termination

date, the plan shall permit payment of any premium for continuation coverage during the preceding period to be made within 45 days of the date of the election.

(iii) PREMIUM DEFINED.—As used in this subparagraph, the term "premium" means any amount payable with respect to the provision of coverage under a group health plan.

(F) NOTICE REQUIREMENTS.—In accordance with regulations of the Secretary—

(i) the group health plan must provide, at the time of commencement of coverage under the plan, for written notice to each covered employee and spouse of the employee (if any) of the rights provided under this paragraph;

(ii) the employer of a employee under the plan must notify the group health plan administrator if the employee dies;

(iii) each covered employee is responsible for notifying the group health plan administrator of the occurrence of any qualifying event (other than that described in subparagraph (C)(i)(I)) respecting that employee; and

(iv) the group health plan administrator must notify each qualified beneficiary, within a period of 14 days after the date the administrator is notified concerning the occurrence of a qualifying event affecting that beneficiary, of—

(I) the termination date with respect to the beneficiary, and

(II) the beneficiary's right to elect continuation coverage under this paragraph and the election period established under subparagraph (B)(i) during which the beneficiary can exercise that right.

(G) DEFINITIONS.—For purposes of this paragraph—

(i) COVERED EMPLOYEE.—The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

(ii) QUALIFIED BENEFICIARY.—The term qualified beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the date before the date of a qualifiying event for that employee—

(I) is a beneficiary under the plan as the spouse of the employee and has been married to the employee for at least the immediately preceding 30-day period, or

(II) is a beneficiary under the plan as a covered dependent child of the employee.

(iii) COVERED DEPENDENT CHILD.—The term "covered dependent child" means, with respect to a covered employee, an individual who meets the generally applicable requirements of the plan for treatment as a depend-

ent child coverd under the plan by reason of the coverage of the employee under the plan.

(iv) GROUP HEALTH PLAN ADMINISTRATOR.—The term "group health plan administrator" means, in connection with a group health plan, any person who provides for administrative functions relating to enrollment of individuals under the plan. For purposes of this subparagraph, the term "person" includes one or more individuals, governments or agencies of the United States or any State or political subdivision thereof, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint ventures, joint stock companies, societies, trusts, unincorporated organizations, trustees, trustees in bankruptcy, receivers, and fiduciaries.

[(2)] *(3)* GROUP HEALTH PLAN.—For purposes of this subsection the term "group health plan" means any plan of, or contributed to by, an employer to provide medical care (as defined in section 213(d)) to his employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise.

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CHAPTER 2—TAX ON SELF-EMPLOYMENT INCOME

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SEC. 1402. DEFINITIONS.

(a) NET EARNINGS FROM SELF-EMPLOYMENT* * *

(b) SELF-EMPLOYMENT INCOME.—The term "self-employment income" means the net earnings from self-employment derived by an individual (other than nonresident alien individual, except as provided by an agreement under section 233 of the Social Security Act) during any taxable year; except that such term shall not include—

(1) that part of the net earnings from self-employment which is in excess of (i) an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective for the calendar year in which such taxable year begins, minus (ii) the amount of the wages paid to such individual during such taxable years; or

(2) the net earnings from self-employment, if such net earnings for the taxable year are less than $400.

For purposes of clause (1), the term "wages" (A) includes such remuneration paid to an employee for services included under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or under an agreement entered into pursuant to the provisions of section 3121 (1) (relating to coverage of citizens of the United States who are employees of foreign affiliates of American employers), as would be wages under section 3121(a) if such services constituted employment under section 3121(b), (B) includes compensation

which is subject to the tax imposed by section 3201 or 3211, and (C) includes, but only with respect to the tax imposed by section 1401(b), remuneration paid for [medicare qualified Federal employment (as defined in section 3121(u)(2))] *medicare qualified government employment (as defined in section 3121(u)(3))* which is subject to the taxes imposed by section 3101(b) and 3111(b). An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for purposes of this chapter be considered to be a nonresident alien individual.

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Subtitle C—Employment Taxes and Collection of Income Tax at Source

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CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

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Subchapter C—General Provisions

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Sec. 3125. Returns in the case of governmental employees in *States*, Guam, American Samoa, and the District of Columbia.

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SEC. 3121. DEFINITIONS.

(a) WAGES.—* * *

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[(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL EMPLOYMENT.—

[(1) IN GENERAL.—For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof.

[(2) MEDICARE QUALIFIED FEDERAL EMPLOYMENT.—For purposes of this chapter, the term "medicare qualified Federal employment" means service which—

[(A) is employment (as defined in subsection (b)) with the application of paragraph (1), but

[(B) would not be employment (as so defined) without the application of paragraph (1).]

(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL, STATE, AND LOCAL EMPLOYMENT.—

(1) FEDERAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof.

(2) STATE AND LOCAL EMPLOYMENT.—For purposes of the taxes imposed by sections 3101(b) and 3111(b)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), subsection (b) shall be applied without regard to paragraph (7) thereof.

(B) EXCEPTION FOR CERTAIN SERVICES.—Service shall not be treated as employment by reason of subparagraph (A) if—

(i) the service is included under an agreement under section 218 of the Social Security Act, or

(ii) the service is performed—

(I) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(II) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(III) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

(IV) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this subparagraph, the terms "State" and "political subdivision" have the meanings given those terms in section 218(b) of the Social Security Act.

(C) EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.—Service performed for an employer shall not be treated as employment by reason of subparagraph (A) if—

(i) such service would be excluded from the term "employment" for purposes of this chapter if subparagraph (A) did not apply;

(ii) such service is performed by an individual—

(I) who was performing substantial and regular service for remuneration for that employer before January 1, 1986,

(II) who is a bona fide employee of that employer on December 31, 1985, and

(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(iii) the employment relationship with that employer has not been terminated after December 31, 1985.

(D) TREATMENT OF AGENCIES AND INSTRUMENTALITIES.—For purposes of subparagraph (C), under regulations—

(i) All agencies and instrumentalities of a State (as defined in section 218(b) of the Social Security Act) or of the District of Columbia shall be treated as a single employer.

(ii) All agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).

(3) MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.—For purposes of this chapter, the term "medicare qualified government employment" means service which—

(A) is employment (as defined in subsection (b)) with the application of paragraphs (2) and (2), but

(B) would not be employment (as so defined) without the application of such paragraphs.

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SEC. 3122. FEDERAL SERVICE.

In the case of the taxes imposed by this chapter with respect to service performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, [including service which is medicare qualified Federal employment (as defined in section 3121(u)(2)),] *including such service which is medicare qualified government employment (as defined in section 3121(u)(3)),* including service, performed as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the determination whether an individual has performed service which constitutes employment as defined in section 3121(b), the determination of the amount of remuneration for such service which constitutes wages as defined in section 3121(a), and the return and payment of the taxes imposed by this chapter, shall be made by the head of the Federal agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to such service without regard to the contribution and benefit base limitation in section 3121(a)(1), and he shall not be required to obtain a refund of the tax paid under section 3111 on that part of the remuneration not included in wages by reason of section 3121(a)(1). Payments of the tax imposed under section 3111 with respect to service, performed by an individual as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, shall be made from appropriations available for the pay of members of such uniformed service. The provisions of this section shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of this section the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of this section shall be applicable

also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Transportation, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of this section the Secretary of Transportation shall be deemed to be the head of such instrumentality.

SEC. 3125. RETURNS IN THE CASE OF GOVERNMENTAL EMPLOYEES IN STATES, GUAM, AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.

(a) STATES.—Except as otherwise provided in this section, in the case of the taxes imposed by sections 3101(b) and 3111(b) with respect to service performed in the employ of a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby), the return and payment of such taxes may be made by the head of the agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).

[(a)**]** *(b)* GUAM.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of Guam or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of Guam or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).

[(b)**]** *(c)* AMERICAN SAMOA.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of American Samoa or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of American Samoa or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to service of such individuals without regard to the contribution and benefits base limitation in section 3121(a)(1).

[(c)**]** *(d)* DISTRICT OF COLUMBIA.—In the case of the taxes imposed by this chapter with respect to service performed in the employ of the District of Columbia or in the employ of any instrumentality which is wholly owned thereby, the return and payment of the taxes may be made by the Mayor of the District of Columbia

or such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed by section 3111 with respect to such service without regard to the contribution and benefit base limitation in section 3121(a)(1).

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UNEMPLOYMENT REPAYMENT TAX

CHAPTER 23A—RAILROAD UNEMPLOYMENT REPAYMENT TAX

* * * * * * *

SEC. 3321. IMPOSITION OF TAX.

(a) GENERAL RULE.—There is hereby imposed on every rail employer for each taxable period an excise tax, with respect to having individuals in his employ, equal to the applicable percentage of the total rail wages paid by him during the taxable period.

(b) TAX ON EMPLOYEE REPRESENTATIVES.—

(1) IN GENERAL.—There is hereby imposed on the income of each employee representative a tax equal to the applicable percentage of the rail wages paid to him during the taxable period.

(2) DETERMINATION OF WAGES.—The rail wages of an employee representative for purposes of paragraph (1) shall be determined in the same manner and with the same effect as if the employee organization by which employee representative is employed were a rail employer.

[(c) RATE OF TAX.—For purposes of this section—

[(1) FOR TAXABLE PERIOD JULY 1 THROUGH DECEMBER 31, 1986.—The applicable percentage for the taxable period beginning on July 1, 1986, and ending on December 31, 1986, shall be 2 percent.

[(2) SUBSEQUENT TAXABLE PERIODS.—The applicable percentage for any taxable period beginning after 1986 shall be the sum of—

[(A) 2 percent, plus

[(B) 0.3 percent for each preceding taxable period.

[In no event shall the applicable percentage exceed 5 percent.]

(c) RATE OF TAX.—For purposes of this section—

(1) IN GENERAL.—The applicable percentage for any taxable period shall be the sum of—

(A) the basic rate for such period, and

(B) the surtax rate (if any) for such period.

(2) BASIC RATE.—For purposes of paragraph (1)—

(A) FOR PERIODS BEFORE 1989.—The basic rate shall be—

(i) 4.3 percent for the taxable period beginning on July 1, 1986, and ending on December 31, 1986.

(ii) 4.7 percent for the 1987 taxable period, and

(iii) 6 percent for the 1988 taxable period.

(B) FOR PERIODS AFTER 1988.—For any taxable period beginning after December 31, 1988, the basic rate shall be the sum of—

(i) 2.9 percent, plus

(ii) 0.3 percent for each preceding taxable period after 1988.

In no event shall the basic rate under this subparagraph exceed 5 percent.

(3) SURTAX RATE.—For purposes of paragraph (1), the surtax rate shall be—

(A) 3.5 percent for any taxable period if, as of September 30 of the preceding calendar year, there was a balance of transfers (or unpaid interest thereon) made after September 30, 1985, to the railroad unemployment insurance account under section 10(d) of the Railroad Unemployment Insurance Act, and

(B) zero for any other taxable period.

(4) BASIC RATE NOT TO APPLY TO RAIL WAGES PAID AFTER SEPTEMBER 30, 1990.—The basic rate under paragraph (1)(A) shall not apply to rail wages paid after September 30, 1990.

SEC. 3322. TAXABLE PERIOD.

(a) GENERAL RULE.—For purposes of this chapter, except as provided in subsection (b), the term "taxable period" means—

(1) the period beginning on July 1, 1986, and ending on December 31, 1986, *and*

[(2) each calendar year after 1986 and before 1990, and

[(3) the period beginning on January 1, 1990, and ending on September 30, 1990.]

(2) each calendar year after 1986.

(b) EARLIER TERMINATION IF LOANS TO RAIL UNEMPLOYMENT FUND REPAID.—[The tax imposed by this chapter shall not apply] *The basic rate under section 3321(c)(1)(A) of the tax imposed by section 3321 shall not apply* to any rail wages paid on or after the first Juanuary 1 after 1986 as of which there is—

(1) no balance of transfers *made before October 1, 1985,* to the railroad unemployment insurance account under section 10(d) of the Railroad Unemployment Insurance Act, and

(2) no unpaid interest on such transfers.

SEC. 3323. OTHER DEFINITIONS.

(a) RAIL EMPLOYER.—For purposes of this chapter, the term "rail employer" means any person who is an employer as defined in section 1 of the Railroad Unemployment Insurance Act.

[(b) RAIL WAGES.—

[(1) IN GENERAL.—For purposes of this chapter, the term "rail wages" means wages as defined in section 3306(b) with the modifications specified in paragraph (2).

[(2) MODIFICATIONS.—In applying subsection (b) of section 3306 for purposes of paragraph (1)—

[(A) ONLY RAILROAD EMPLOYMENT TAKEN INTO ACCOUNT.—Such subsection (b) shall be applied—

[(i) by substituting "rail employment" for "employment" each place it appears, and

[(ii) by substituting "rail employer" for "employer" each place it appears.

[(B) WAGE BASE FOR FIRST TAXABLE PERIOD.—In the case of the taxable period beginning on July 1, 1986, and ending on December 31, 1986, such subsection (b) shall be applied by substituting "$3,500" for "$7,000" each place it appears in paragraph (1) thereof.

[(C) WAGE BASE FOR LAST TAXABLE PERIOD.—In the case of the taxable period beginning on January 1, 1990, and ending on September 30, 1990, such subsection (b) shall be applied by substituting "$5,250" for "$7,000" each place it appears in paragraph (1) thereof.]

(b) RAIL WAGES.—

(1) IN GENERAL.—For purposes of this chapter, the term "rail wages means compensation (as defined in section 3231(e) for purposes of the tax imposed by section 3201(a) with the modifications specified in paragraph (2).

(2) MODIFICATIONS.—In applying subsection (e) of section 3231 for purposes of paragraph (1)—

(A) ONLY EMPLOYMENT COVERED BY RAILROAD UNEMPLOYMENT INSURANCE ACT TAKEN INTO ACCOUNT.—Such subsection (e) shall be applied—

(i) by substituting "rail employment" for "services" each place it appears,

(ii) by substituting "rail employer" for "employer" each place it appears, and

(iii) by substituting "rail employee" for "employee" each place it appears.

(B) $7,000 WAGE BASE.—Such subsection (e) shall be applied by substituting for "the applicable base" in paragraph (2)(A)(i) thereof—

(i) except as provided in clauses (ii) and (iii), "$7,000",

(ii) "$3,500" for the taxable period beginning on July 1, 1986, and ending on December 31, 1986, and

(iii) for purposes of applying the basic rate under section 3321(c)(1)(A), "$5,250" for the taxable period beginning on January 1, 1990.

(C) SUCCESSOR EMPLOYERS.—For purposes of this subsection, rules similar to the rules applicable under section 3231(e)(2)(C) shall apply.

(c) RAIL EMPLOYMENT.—For purposes of this chapter, the term "rail employment" means services performed by an individual as a rail employee or employee representative.

(d) RAIL EMPLOYEE AND EMPLOYEE REPRESENTATIVE.—For purposes of this chapter—

(1) RAIL EMPLOYEE.—The term "rail employee" means any person who is an employee as defined in section I of the Railroad Unemployment Insurance Act.

(2) EMPLOYEE REPRESENTATIVE.—The term "employee representative" has the meaning given such term by section 1 of the Railroad Unemployment Insurance Act.

(e) CONCURRENT EMPLOYMENT BY 2 OR MORE RAIL EMPLOYERS.—For purposes of this chapter, if 2 or more related corporations

which are rail employers concurrently employ the same individual and compensate such individual through a common paymaster which is 1 of such corporations, each such corporation shall be considered to have paid as remuneration to such individual only the amounts actually disbursed by it to such individual and shall not be considered to have paid as remuneration to such individual amounts actually disbursed to such individual by another of such corporations.

(f) CERTAIN RULES MADE APPLICABLE.—For purposes of this chapter, rules similar to the rules of sections 3307 and 3308 shall apply.

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Subtitle D—Miscellaneous Excise Taxes

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CHAPTER 32—MANUFACTURERS EXCISE TAXES

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Subchapter B—Coal

Sec. 4121. Imposition of tax.

SEC. 4121. IMPOSITION OF TAX

[(a) TAX IMPOSED.—There is hereby imposed on coal sold by the producer a tax at the rates of—

[(1) 50 cents per ton in the case of coal from underground mines located in the United States, and

[(2) 25 cents per ton in the case of coal from surface mines located in the United States.

[(b) LIMITATION ON TAX.—The amount of the tax imposed by subsection (a) with respect to a ton of coal shall not exceed 2 percent of the price at which such ton of coal is sold by the producer.]

(a) TAX IMPOSED.—

(1) IN GENERAL.—There is hereby imposed on coal from mines located in the United States sold by the producer a tax equal to the rate per ton determined under subsection (b).

(2) LIMITATION ON TAX.—The amount of the tax imposed by paragraph (1) with respect to a ton of coal shall not exceed the applicable percentage (determined under subsection (b)) of the price at which such ton of coal is sold by the producer.

(b) DETERMINATION OF RATES AND LIMITATION ON TAX.—For purposes of subsection (a)—

In the case of sales during calendar year:	*The rate for coal from underground mines is:*	*The rate for coal from surface mines is:*	*The applicable percentage is:*
1986 through 1990	*$1.50*	*$.75*	*6*
1991 through 1995	*$1.60*	*$.80*	*6.4*
After 1995	*$1.50*	*$.75*	*6.*

(c) TAX NOT TO APPLY TO LIGNITE.—The tax imposed by subsection (a) shall not apply in the case of lignite.

(d) DEFINITIONS.—For purposes of this subchapter—

(1) COAL FROM SURFACE MINES.—Coal shall be treated as produced from a surface mine if all of the geological matter above the coal being mined is removed before the coal is extracted from the earth Coal extracted by auger shall be treated as coal from a surface mine.

(2) COAL FROM UNDERGROUND MINES.—Coal shall be treated as produced from an underground mine if it is not produced from a surface mine.

(3) UNITED STATES.—The term "United States" has the meaning given to it by paragraph (1) of section 638.

(4) TON.—The term "ton" means 2,000 pounds.

(e) TEMPORARY INCREASE IN AMOUNT OF TAX—

(1) IN GENERAL.—Effective with respect to sales after December 31, 1981, and before the temporary increase termination date—

[(A) subsection (a) shall be applied—

[(i) by substituting "$1" for "50 cents", and

[(ii) by substituting "50 cents" for "25 cents", and

[(B) subsection (b) shall be a applied by substituting "4 percent" for "2 percent".

[(2) TEMPORARY INCREASE TERMINATION DATE.—For purposes of paragraph (1), the temporary increase termination date as the earlier of—

[(A) January 1, 1996, or

[(B) the first January 1 after 1981 as of which there is—

[(i) no balance of repayable advances made to the Black Lung Disability Trust Fund, and

[(ii) no unpaid interest on such advances.]

(e) REDUCTION OF TAX AFTER 1995 IF LOANS MADE TO BLACK LUNG DISABILITY TRUST FUND REPAID.—

(1) IN GENERAL.—In the case of sales during any calendar year to which this subsection applies, for purposes of subsection (a)—

(A) the rate of tax on coal from underground mines shall be $1.00,

(B) the rate of tax on coal from surface mines shall be $.50, and

(C) the applicable percentage shall be 4 percent.

(2) CALENDAR YEARS TO WHICH SUBSECTION APPLIES.—This subsection shall apply to any calendar year after 1995 (and all calendar years thereafter) if throughout the 2 most recent fiscal years ending before the beginning of such calendar year there was—

(A) no balance of repayable advances made to the Black Lung Disability Trust Fund, and

(B) no unpaid Interest on such advances.

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Subtitle F—Procedure and Administration

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CHAPTER 63—ASSESSMENT

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Subchapter A—In General

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SEC 6205. SPECIAL RULES APPLICABLE TO CERTAIN EMPLOYMENT TAXES.

(a) ADJUSTMENT OF TAX.—

(1) GENERAL RULE.—If less than the correct amount of tax imposed by sections 3101, 3111, 3201, 3221, or 3402 is paid with respect to any payment of wages or compensation, proper adjustments, with respect to both the tax and the amount to be deducted, shall be made, without interest, in such manner and at such times as the Secretary may by regulations prescribe.

(2) UNITED STATES AS EMPLOYER.—For purposes of the subsection, in the case of remuneration received from the United States or a wholly-owned instrumentality thereof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall be deemed a separate employer.

(3) GUAM OF AMERICAN SAMOA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calendar year from the Government of Guam, the Government of American Samoa, a political subdivision of either, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, the Governor of Guam, the Governor of American Samoa, and each agent designated by either who makes a return pursuant to section 3125 shall be deemed a separate employer.

(4) DISTRICT OF COLUMBIA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calendar year from the District of Columbia or any instrumentality which is wholly owned thereby, the Mayor of the District of Columbia and each agent designated by him who makes a return pursuant to section 3125 shall be deemed a separate employer.

(5) STATES AND POLITICAL SUBDIVISIONS AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or insirumentality, and each agent designated by either,

who makes a return pursuant to section 3125 shll be deemed a separate employer.

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CHAPTER 65—ABATEMENTS, CREDITS, AND REFUNDS

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Subchapter B—Rules of Special Application

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SEC. 6413. SPECIAL RULES APPLICABLE TO CERTAIN EMPLOYMENT TAXES.

(a) ADJUSTMENT OF TAX.—

(1) GENERAL RULE.—If more than the correct amount of tax imposed by section 3101, 3111, 3201, 3221, or 3402 is paid with respect to any payment of remuneration, proper adjustments, with respect to both the tax and the amount to be deducted, shall be made, without interest, in such manner and at such times as the Secretary may by regulations prescribe.

(2) UNITED STATES AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received from the United States or a wholly-owned instrumentality thereof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall be deemed a separate employer.

(3) GUAM OR AMERICAN SAMOA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calendar year from the Government of Guam, the Government of American Samoa, a political subdivision of either, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, the Governor of Guam, the Governor of American Samoa, and each agent designated by either who makes a return pursuant to section 3125 shall be deemed a separate employer.

(4) DISTRICT OF COLUMBIA AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received during any calender year from the District of Columbia or any instrumentality which is wholly owned thereby, the Mayor of the District of Columbia and each agent designated by him who makes a return pursuant to section 3125 shall be deemed a separate employer.

(5) STATES AND POLITICAL SUBDIVISIONS AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentali-

ty, and each agent designated by either, who makes a return pursuant to section 3125 shall be deemed a separate employer.

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(c) SPECIAL REFUNDS.—

(1) IN GENERAL.—If by reason of an employee receiving wages from more than one employer during a calendar year the wages received by him during such year exceed the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective with respect to such year, the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101 or section 3201, or by both such sections, and deducted from the employee's wages (whether or not paid to the Secretary), which exceeds the tax with respect to the amount of such wages received in such year which is equal to such contribution and benefit base. The term "wages" as used in this paragraph shall, for purposes of this paragraph, include "compensation" as defined in section 3231(e).

(2) APPLICABILITY IN CASE OF FEDERAL AND STATE EMPLOYEES, EMPLOYEES OF CERTAIN FOREIGN AFFILIATES, AND GOVERNMENTAL EMPLOYEES IN GUAM, AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.—

(A) FEDERAL EMPLOYEES.—In the case of remuneration received from the United States or a wholly owned instrumentality thereof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall, for purposes of this subsection, be deemed a separate employer, and the term "wages" includes, for purposes of this subsection, the amount, not to exceed an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) for any calendar year with respect to which such contribution and benefit base is effective, determined by each such head or agent as constituting wages paid to an employee.

(B) STATE EMPLOYEES.—For purposes of this subsection, in the case of remuneration received during any calendar year, the term "wages" includes such remuneration for services covered by an agreement made pursuant to section 218 of the Social Security Act as would be wages if such services constituted employment; the term "employer" includes a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing; the term "tax" or "tax imposed by section 3101" includes, in the case of services covered by shall apply whether or not any amount deducted from the employee's remuneration as a result of an agreement made pursuant to section 218 of the Social Security Act has been paid to the Secretary.

(C) EMPLOYEES OF CERTAIN FOREIGN AFFILIATES.—For purposes of paragraph (1) of this subsection, the term "wages" includes such remuneration for services covered by an agreement made pursuant to section 3121(1) as would be wages if such services constituted employment; the term "employer" includes any American employer which has entered into an agreement pursuant to section 3121(1); the term "tax" or "tax imposed by section 3101" includes, in the case of services covered by an agreement entered into pursuant to section 3121(1), an amount equivalent to the tax which would be imposed by section 3101, if such services constituted employment as defined in section 3121; and the provisions of paragraph (1) of this subsection shall apply whether or not any amount deducted from the employee's remuneration as a result of the agreement entered into pursuant to section 3121(1) has been paid to the Secretary.

(D) GOVERNMENTAL EMPLOYEES IN GUAM.—In the case of remuneration received from the Government of Guam or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby during any calendar year, the Governor of Guam and each agent designated by him who makes a return pursuant to section [3125(a)] *3125(b)* shall, for purposes of this subsection, be deemed a separate employer.

(E) GOVERNMENTAL EMPLOYEES IN AMERICAN SAMOA.—In the case of remuneration received from the Government of American Samoa or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby, during any calendar year, the Governor of American Samoa and each agent designated by him who makes a return pursuant to section [3125(b)] *3125(c)* shall, for purposes of this subsection, be deemed a separate employer.

(F) GOVERNMENTAL EMPLOYEES IN THE DISTRICT OF COLUMBIA.—In the case of remuneration received from the District of Columbia or any instrumentality wholly owned thereby, during any calendar year, the Mayor of the District of Columbia and each agent designated by him who makes a return pursuant to section [3125(c)] *3125(d)* shall, for purposes of this subsection, be deemed a separate employer.

(G) EMPLOYEES OF STATES AND POLITICAL SUBDIVISIONS.—In the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by either, who makes a return pursuant to section 3125(a) shall, for purposes of this subsection, be deemed a separate employer.

(3) APPLICABILITY WITH RESPECT TO COMPENSATION OF EMPLOYEES SUBJECT TO THE RAILROAD RETIREMENT TAX ACT.—In the case of any individual who, during any calendar year, receives wages from one or more employers and also receives compensation

which is subject to the tax imposed by section 3201 or 3211, such compensation shall, solely for purposes of applying paragraph (1) with respect to the tax imposed by section 3101(b), be treated as wages received from an employer with respect to which the tax imposed by section 3101(b) was deducted.

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Subtitle I—Trust Fund Code

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CHAPTER 98—TRUST FUND CODE

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Subchapter A—Establishment of Trust Funds

Sec. 9501. Black Lung Disability Trust Fund.
Sec. 9505. Tobacco Equalization Trust Fund.

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SEC. 9505. TOBACCO EQUALIZATION TRUST FUND.

(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the "Tobacco Equalization Trust Fund", consisting of such amounts as may be appropriated or credited to the Tobacco Equalization Trust Fund as provided in this section or section 9602(b).

(b) TRANSFERS TO TOBACCO EQUALIZATION TRUST FUND.—There is hereby appropriated to the Tobacco Equalization Trust Fund an amount to so much of the taxes received in the Treasury after September 30, 1985, and before October 1, 1990, under section 5701(b) (relating to tax on cigarettes) as is attributable to such tax determined at the rates of—

(1) 50 cents per thousand in the case of cigarettes taxable under section 5701(b)(1), and

(2) $1.05 per thousand in the case of cigarettes taxable under section 5701(b)(2).

(c) EXPENDITURES FROM TRUST FUND.—Equalization Trust Fund shall be available, as provided in appropriation Acts, for the reimbursement of the Commodity Credit Corporation for part or all of the amount of any net realized losses sustained after September 30, 1985, by such Corporation under section 106, 106A, or 106B of the Agricultural Act of 1949 (or any successor tobacco support provision hereafter enacted) with respect to crop years of tobacco after 1981.

(2) REPAYMENTS AND CREDITS.—The Secretary shall pay from time to time from the Tobacco Equalization Trust Fund to the general fund of the Treasury amounts equivalent to the same proportion of the credits allowed, and refunds made, after September 30, 1985, and before October 1, 1990, with respect to the tax imposed by section 5701(b) as the portion the tax imposed by

section 5701(b) appropriated to the Tobacco Equalization Trust Fund bears to the aggregate tax imposed by section 5701(b).

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AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967

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PROHIBITION OF AGE DISCRIMINATION

SEC. 4. (a) * * *

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(g)(1) For purposes of this section, any employer must provide that any employee aged 65 [through 69,] *or older,* and any employee's spouse aged 65 [through 69,] shall be entitled to coverage under any group health plan offered to such employees under the same conditions as any employee, and the spouse of such employee, under age 65.

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AGE LIMITATION

SEC. 12. (a) The prohibitions in this Act *(except the provisions of section 4(g))* shall be limited to individuals who are at least 40 years of age but less than 70 years of age.

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TRADE ACT OF 1974

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TITLE I—NEGOTIATING AND OTHER AUTHORITY

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CHAPTER 4—OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

SEC. 141. OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE.

(a) * * *

* * * * * * *

(d) The United States Trade Representative may, for the purpose of carrying out his functions under this section—

(1) subject to the civil service and classification laws, select, appoint, employ, and fix the compensation of such officers and employees as are necessary and prescribe their authority and duties, *except that not more than 20 individuals may be employed without regard to any provision of law regulating the*

employment or compensation at rates not to exceed the rate of pay for level IV of the Executive Schedule in section 5314 of title 5, United States Code

* * * * * * *

(f)(1) There are authorized to be appropriated to the Office for the purpose of carrying out its functions [$14,179,000 for fiscal year 1985;] *$13,582,000 for fiscal year 1986;* of which not to exceed [$80,000] *$68,000* may be used for entertainment and representation expenses.

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TITLE II—RELIEF FROM INJURY CAUSED BY IMPORT COMPETITION

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CHAPTER 2—ADJUSTMENT ASSISTANCE FOR WORKERS

Subchapter A—Petitions and Determinations

* * * * * * *

[SEC. 222. GROUP ELIGIBILITY REQUIREMENTS.

[The Secretary shall certify a group of workers as eligible to apply for adjustment assistance under this chapter if he determines—

[(1) that a significant number or proportion of the workers in such workers' firm or an appropriate subdivision of the firm have become totally or partially separated, or are threatened to become totally or partially separated.

[(2) that sales or production, or both, of such firm or subdivision have decreased absolutely, and

[(3) that increases imports of articles like or directly competitive with articles produced by such workers' firm or an appropriate subdivision thereof contributed importantly to such total or partial separation, or threat thereof, and to such decline in sales or production.

For purposes of paragraph (3), the term "contributed importantly" means a cause which is important, but not necessarily more important than any other cause.]

SEC. 222. GROUP ELIGIBILTY REQUIREMENTS.

The Secretary shall certify a group of workers as eligible to apply for adjustment assistance under this part if he determines—

(1) that—

(A) a signficant number or proportion of the workers in such workers' firm or an appropriate subdivision of the firm have become totally or partially separated, or are threatened to become totally or partially separated,

(B) sales or production, or both, of such firm or subdivision have decreased absolutely, and

(C) increases of imports of articles like or directly competitive with articles produced by such workers' firm or an appropriate subdivision thereof contributed importantly to such total or partial separation, or threat thereof, and to such decline in sales or production; or

(2) that a significant number or proportion of the workers in such workers' firm (if the firm has no subdivision) or subdivision of a firm have become totally or partially separated, or are threatened to become totally or partially separated, by reason of the relocation of the production functions of that firm or subdivision to a foreign country or instrumentality.

For purposes of paragraph (1)(C), the term "contributed importantly" means a cause which is important but not necessarily more important than any other cause.

* * * * * * *

Subchapter B—Program Benefits

PART I—TRADE READJUSTMENT ALLOWANCES

SEC. 231. QUALIFYING REQUIREMENTS FOR WORKERS.

(a) Payment of a trade readjustment allowance shall be made to an adversely affected worker covered by a certification under subchapter A who files an application for such allowance for any week of unemployment which begins more than 60 days after the date on which the petition that resulted in such certification was filed under section 221, if the following conditions are met:

(1) * * *

(2) Such worker had, in the 52-week period ending with the week in which such total or partial separation occured, at least 26 weeks of employment at wages of $30 or more a week in adversely affected employment with a single firm or subdivision of a firm, or, if data with respect to weeks of employment with a firm are not available, equivalent amounts of employment computed under regulations prescribed by the Secretary. For the purposes of this paragraph, any week in which such worker—

(A) is on employer-authorized leave for purposes of vaction, sickness, injury, maternity, or inactive duty or active duty military service for training,

(B) does not work because of a disability that is compensable under a workmen's compensation law or plan of a State or the United States, or

(C) had his employment interrupted in order to serve as a full-time representative of a labor organization in such firm or subdivision,

[shall be treated as a week of employment at wages of $30 or more, but not more than the following number of weeks may be treated as such weeks of employment under this sentence:

[(i) 3 weeks if no weeks described in subparagraph (B) occurred during the 52-week period concerned.

(ii) 7 weeks if all are weeks described in subparagraph (B).

[(iii) 7 weeks in the case of weeks described in subparagraphs (B) and (A) or (C), or both, except that not more than 3 of such weeks may be other than weeks described in subparagraph (B).]

shall be treated as a week of employment at wages of $30 or more, but not more than 7 weeks, in case of weeks described in paragraph (A) or (C), or both, may be treated as weeks of employment under this sentence.

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SEC. 233. LIMITATIONS ON TRADE READJUSTMENT ALLOWANCES.

(a)(1) * * *

(2) A trade readjustment allowance shall not be paid for any week after the [52-week] *104-week* period beginning with the first week following the first week in the period covered by the certification with respect to which the worker has exhausted (as determined for purposes of section 231(a)(3)(B)) all rights to that part of his unemployment insurance that is regular compensation.

* * * * * * *

SEC. 236. TRAINING.

(a)(1) If the Secretary determines that—

(A) there is no suitable employment (which may include technical and professional employment) available for a worker,

(B) the worker would benefit from appropriate training,

(C) there is a reasonable expectation of employment following completion of such training,

(D) training approved by the Secretary is available to the worker from either governmental agencies or private sources (which may include area vocational education schools, as defined in section 195(2) of the Vocational Education Act of 1963, and employers), and

(E) the worker is qualified to undertake and complete such training,

the Secretary may approve such training for the worker. Upon such approval, the worker shall be entitled to have payment of the costs of such training paid on his behalf by the Secretary. Insofar as possible, the Secretary shall provide or assure the provision of such training on the job, which shall include related education necessary for the acquisition of skills needed for a position within a particular occupation. *For purposes of applying subparagraph (C), a reasonable expectation of employment does not require that employment opportunities for a worker be available, or offered, immediately upon the completion of training under this section.*

* * * * * * *

Subchapter C—General Provisions

SEC. 239. AGREEMENTS WITH STATES.

(a)(1) The Secretary is authorized on behalf of the United States to enter into an agreement with any State, or with any State agency (referred to in this subchapter as "cooperating States" and "cooperating States agencies" respectively). Under such an agree-

ment, the cooperating State agency [(1)] *(A)* as agent of the United States, will receive applications for, and will provide, payments on the basis provided in this chapter, [(2) where appropriate, will afford adversely affected workers testing, counseling, referral to training, and placement services, and (3)] *(B) where appropriate, but in accordance with paragraph (2), will afford adversely affected workers testing, counseling, referred to training, and placement services, and (C)* will otherwise cooperate with the Secretary and with other State and Federal agencies in providing payments and services under this chapter.

(2) Each cooperating State agency must, in carrying out paragraph (1)(B)—

(A) advise each adversely affected worker to apply for training under section 236(a) at the time the worker makes application for trade readjustment allowances (but failure of the worker to do so may not be treated as cause for denial of those allowances); and

(B) within 60 days after application for training is made by the worker, interview the adversely affected worker regarding, and review, suitable training opportunities available to the worker under section 236.

* * * * * * *

CHAPTER 3—ADJUSTMENT ASSISTANCE FOR FIRMS

SEC. 251. PETITIONS AND DETERMINATIONS.

(a) * * *

* * * * * * *

(c) The Secretary shall certify a firm as eligible to apply for adjustment assistance under this chapter if he determines—

(1) that a significant number or proportion of the workers in such firm have become totally or partially separated, or are threatened to become totally or partially separated,

[(2) that sales or production, or both, of such firm have decreased absolutely, and]

(2) sales or production, or both—

(A) of the firm have decreased absolutely, or

(B) of an article that accounted for not less than 25 percent of the total production or sales of the firm during the 12-month period preceding the most recent 12-month period for which data are available have decreased absolutely, and

* * * * * * *

SEC. 252. APPROVAL OF ADJUSTMENT PROPOSALS.

(a) * * *

(b)(1) Adjustment assistance under this chapter consists of technical assistance and financial assistance, which may be furnished singly or in combination. The Secretary shall approve a firm's application for [adjustment assistance] *technical assistance under*

section 253(a)(3) or financial assistance under section 254 only if he determines—

(A) that the firm has no reasonable access to financing through the private capital market, and

(B) that the firm's adjustment proposal—

(i) is reasonably calculated materially to contribute to the economic adjustment of the firm,

(ii) gives adequate consideration to the interests of the workers of such firm, and

(iii) demonstrates that the firm will make all reasonable efforts to use its own resources for economic development.

(2) The Secretary shall make a determination as soon as possible after the date on which an application is filed under this section, but in no event later than 60 days after such date.

[(c) In order to assist a firm which has been certified as eligible to apply for adjustment assistance under this chapter in preparing a viable adjustment proposal, the Secretary may furnish technical assistance to such firm.]

[(d)] *(c)* Whenever the Secretary determines that any firm no longer requries assistance under this chapter, he shall terminate the certification of eligibility of such firm and promptly have notice of such termination published in the Federal Register. Such termination shall take effect on the termination date specified by the Secretary.

SEC. 253. TECHNICAL ASSISTANCE.

(a) * * *

(b)(1) * * *

(2) In the case of assistance furnished *to a certified firm in the implementation of its adjustment proposal* through private individuals, firms, or institutions (including private consulting services), the Secretary may share the cost thereof (but not more than 75 percent of such cost may be borne by the United States).

* * * * * * *

SEC. 254. FINANCIAL ASSISTANCE.

(a) * * *

(b) Loans or guarantees of loans shall be made under this chapter only for the purpose of making funds available *, either through a single loan or a combination of loans,* to the firm—

(1) for acquisition, construction, installation, modernization, development, conversion, or expansion of land, plant, buildings, equipment, facilities, or machinery, or

(2) to supply such working capital as may be necessary to enable the firm to implement its adjustment proposal.

* * * * * * *

SEC. 258. PROTECTIVE PROVISIONS.

(a) * * *

* * * * * * *

(d) No financial assistance shall be provided to any firm under this chapter unless the owners, partners, or officers shall execute an agreement binding [them and] the firm for a period of 2 years after such financial assistance is provided, to refrain from employ-

ing, tendering any office or employment to, or retaining for professional services any person who, on the date such assistance or any part thereof was provided, or within 1 year prior thereto, shall have served as an officer, attorney, agent, or employee occupying a position or engaging in activities which the Secretary shall have determined involve discretion with respect to the provision of such financial assistance.

* * * * * * *

CHAPTER 5—MISCELLANEOUS PROVISIONS

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SEC. 285. EFFECTIVE DATE.

Chapters 2, 3, and 4 of this title shall become effective on the 90th day following the date of enactment of this Act and chapters 2 and 3 shall terminate on September 30, [1985.] *1989.* Chapter 4 shall terminate on September 30, 1982.

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TARIFF ACT OF 1930

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TITLE III—SPECIAL PROVISIONS

* * * * * * *

PART II—United States Tariff Commission

SEC. 330. ORGANIZATION OF THE COMMISSION.

(a) MEMBERSHIP.—* * *

* * * * * * *

(e) AUTHORIZATION OF APPROPRIATIONS.—(1) * * *

(2) [There are authorized to be appropriated to the Commission for necessary expenses (including the rental of conference rooms in the District of Columbia and elsewhere) for fiscal year 1985 not to exceed $28,410,000; of which not to exceed $2,500 may be used, subject to approval by the Chairman of the Commission, for reception and entertainment expenses.] *There are authorized to be appropriated to the Commission for necessary expenses (including the rental of conference rooms in the District of Columbia and elsewhere) for fiscal year 1986 not to exceed $28,901,000; of which not to exceed $2,500 may be used, subject to approval by the Chairman of the Commission, for reception and entertainment expenses.* No part of any sum that is appropriated under the authority of this paragraph may be used by the Commission for the making of any special study, investigation, or report that is requested by any agency of the executive branch unless that agency reimburses the Commission for the cost thereof.

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TITLE IV—ADMINISTRATIVE PROVISIONS

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PART III—ASCERTAINMENT, COLLECTION, AND RECOVERY OF DUTIES

* * * * * * *

[SEC. 524. DEPOSIT OF REIMBURSABLE CHARGES.

[Receipts for any reimbursable charges or expenses which have been paid for out of any appropriation for collecting the revenue from customs shall be deposited as a refund to such appropriation instead of being covered into the Treasury as miscellaneous receipts, as provided by the Act entitled "An Act making appropriations for sundry civil expenses of the Government for the fiscal year ending June 30, 1908, and for other purposes", approved March 4, 1907.]

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CUSTOMS PROCEDURAL REFORM AND SIMPLIFICATION ACT OF 1978

* * * * * * *

TITLE II—CUSTOMS SIMPLIFICATION

* * * * * * *

[SEC. 214. (a) Sections 2654, 4381, 4382, and 4383 of the Revised Statutes of the United States (19 U.S.C. 58 and 46 U.S.C. 329, 330, and 333) are each repealed.

[(b) The Secretary may charge such fees as may be necessary to cover the costs of providing services similar to or the same as services furnished by customs officers under the sections repealed by subsection (a).]

SEC. 214. (a) The Secretary of the Treasury shall charge and collect the following fees to cover the expenses incurred by the Customs Service in processing arrivals at ports of entry in the customs territory of the United States:

(1) For the arrival of a commercial vessel of 100 or more tons, $425.

(2) For the arrival of a commercial truck, $5.

(3) For the arrival of a railroad car, whether passenger or freight, $5.

(4) For all arrivals made during a calendar year by a private aircraft or private vessel, $25.

(5) For the arrival in the United States of each passenger aboard a commercial vessel or commercial aircraft from a place outside the United States other than a place described in paragraph (6), $5.

(6) For the arrival in the United States of each passenger aboard a commercial vessel, commercial aircraft, or train from Canada, Mexico, a territory or possession of the United States, or any island that is an adjacent island within the meaning of

section 101(b)(5) of the Immigration and Nationality Act (8 U.S.C. 1101(b)(5)), $1.

(b) Each person providing transportation for hire by vessel, aircraft, or train shall—

(1) separately identify the fee charged under subsection (a) (5) or (6), as the case may be, as a Federal inspection fee on the document or ticket issued to each passenger for that transportation;

(2) collect the fee from the passenger at the time the documentation or ticket is purchased; and

(3) remit to the Secretary the fees collected under paragraph (2) during each calendar quarter before the 31st day after the last day of that quarter.

(c) Except with respect to those services for which fees are imposed under subsection (a), the Secretary of the Treasury may charge such fees as may be necessary to cover the costs of providing those services which customs officers were authorized to provide under subsection (a), as in effect before the date of the enactment of this subsection.

(d) Notwithstanding any other provision of law, the customs services required to be provided to passengers upon arrival in the United States on scheduled airline flights shall be adequately provided when and where needed that no cost to airlines and airline passengers other than the fees imposed under subsection (a).

(e) the receipts for reimbursable charges, including those collected under subsection (a), and expenses which have been paid for out of any appropriation for collecting the revenue from customs that are covered into the Treasury as miscellaneous receipts under the first section of the Act of March 4, 1907 (19 U.S.C. 527), shall be placed in a proprietary account.

* * * * * * *

TITLE III—CUSTOMS SERVICE APPROPRIATIONS AUTHORIZATION

SEC. 301. (a) For the fiscal year beginning October 1, 1979, and each fiscal year thereafter, there are authorized to be appropriated to the Department of the Treasury for the United States Customs Service only such sums as may hereafter be authorized by law.

[(b) There are authorized to be appropriated to the Department of the Treasury not to exceed $686,399,000 for the salaries and expenses of the United States Customs Service for fiscal year 1985; of which (A) $28,070,000 is for the operation and maintenance of the air interdiction program of the Service, and (B) not to exceed $15,000,000 is for the implementation of the "Operation EXODUS" program and any related program designed to enforce or monitor export controls under the Export Administration Act of 1979.]

(b)(1) There are authorized to be appropriated to the Department of the Treasury not to exceed $769,067,000 for the salaries and expenses of the United States Customs Service for fiscal year 1986; of which—

(A) $27,900,000 is for the addition of 500 inspectors, 150 import specialists, 100 customs patrol officers, and 50 special agents;

(B) $50,425,000 is for the operation and maintenance of the air interdiction program of the Service; and

(C) not to exceed $14,000,000 is for the implementation of the 'Operation EXODUS' program and any related program designed to enforce or monitor export controls under the Export Administration Act of 1979.

(2) No part of any sum that is appropriated under the authority of paragraph (1) may be used to close any port of entry at which, during fiscal year 1985—

(A) not less than 2,500 merchandise entries (including informal entries) were made; and

(B) not less than $1,500,000 in customs revenues were assessed.

(3)(A) No part of any sum that is appropriated under the authority of paragraph (1) may be used for further research and development or acquisition of F–15 avionics for the P–3 aricraft and related equipment until 60 days after the Committee on Ways and Means and the Committee on Finance have received from the Secretary of the Treasury a written comparative assessment of the suitability of the P–3, E–2, or other appropriate aricraft for use by the Customs Service in its air drug interdiction program. Such assessment, which the Secretary may not submit to the Committee until the General Accounting Office study required under paragraph (6) is completed, shall include life costs.

(B) Acquisition of additional aircraft for use by the Customs Service for its air drug interdiction program after completion of the assessment required under subparagraph (A) shall be subject to competitive bidding through the use of the normal "request for proposal" process.

(4) No part of any sum that is appropriated under the authority of paragraph (1) may be used to consolidate the drawback liquidation centers within the Customs Service to less than 4 such centers. If a consolidation is undertaken, the Commissioner of Customs shall select the location of the centers after taking into account the drawback volume at, and the geographic dispersion of the respective centers being considered for consolidation.

(5) In addition to any sum authorized to be appropriated under paragraph (1), there are authorized to be appropriated to the Department of the Treasury for fiscal year 1986—

(A) not to exceed $8,000,000 from the Customs Forfeiture Fund for the making of payments under section 613A of the Tariff Act of 1930 (19 U.S.C. 1613b), of which not to exceed $5,000,000 may be used for the modification of aircraft (whether or not aircraft described in subsection (a)(5) of that section) for drug interdiction; and

(B) from the Treasury account established under section 236 of the Trade and Tariff Act of 1984 (19 U.S.C. 58b) such sums as may be necessary for the provision of customs services at airports under that section, but not to exceed $75,000 for each such airport; and

(6) As soon as possible after the date of the enactment of this paragraph, but not later than 12 months after that date, the General Accounting Office shall complete, and submit to the Committee on Ways and Means and the Committee on Finance, a study that

evaluates the air detection and interdiction capability of the Customs Service, including assets, geographic dispersal, costs of operation, procurement practices, and the services and equipment provided by other Federal agencies. Within 6 months after commencing the study, the General Accounting Office shall consult with the Committees on the progress of the study.

* * * * * * *

(f) USE OF SAVINGS RESULTING FROM ADMINISTRATIVE CONSOLIDATIONS.—If savings in salaries and expenses result from the consolidation of administrative functions within the Customs Service, the Commissioner of Customs shall apply those savings, to the extent they are not needed to meet emergency requirements of the Service, to strengthening the commercial operations of the Service by increasing the number of inspector, import specialist, patrol officer, and other line operational positions.

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SECTION 305 OF THE RAIL PASSENGER SERVICE ACT

SEC. 305. GENERAL POWERS OF THE CORPORATION.

(a) * * *

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(i) The Secretary of the Treasury and the Attorney General shall (consistent with the effective enforcement of the immigration and customs laws) establish and maintain, in cooperation with the Corporation, en route customs inspection and immigration procedures aboard trains operated in international intercity rail passenger service, which procedures will be convenient for passengers and will result in the most rapid possible transit in international intercity rail passenger service. [The Corporation shall not be obligated to pay any amount to any agency of the Federal Government for the cost of customs inspection or immigration procedures in connection with the provision of services by the Corporation.]

* * * * * * *

SECTION 53 OF THE AIRPORT AND AIRWAY DEVELOPMENT ACT OF 1970

SEC. 53. MAXIMUM CHARGES FOR CERTAIN OVERTIME SERVICES.

(a) * * *

* * * * * * *

[(e) The cost of any inspection or quarantine service which is required to be performed by the Federal Government or any agency thereof at airports of entry or other places of inspection as a consequence of the operation of aircraft, and which is performed during regularly established hours of service on Sundays or holidays shall be reimbursed by the owners or operators of such aircraft only to the same extent as if such service had been performed during regularly established hours of service on weekdays. Notwithstanding any other provision of law, administrative overhead costs associated with any inspection or quarantine service required to be per-

formed by the United States Government, or any agency thereof, at airports of entry as a result of the operation of aircraft, shall not be assessed against the owners or operators thereof.]

SECTION 232 OF THE RAILROAD RETIREMENT REVENUE ACT OF 1983

SEC. 232. TAX USED TO REPAY LOANS MADE TO RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT.

(a) TRANSFER TO RAILROAD RETIREMENT ACCOUNT.—

(1) IN GENERAL.—The Secretary of the Treasury shall transfer from the general fund of the Treasury to the Railroad Retirement Account an amount equal to the additional railroad unemployment taxes received in the Treasury.

[(2) TAXES CREDITED AGAINST LOANS TO RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT.—Any amount transferred under paragraph (1) shall be credited against, and operate to reduce, the outstanding balance of railroad unemployment loans.]

(2) TAXES CREDITED AGAINST LOANS TO RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT.—

(A) TAXES ATTRIBUTABLE TO BASIC RATE TO REDUCE RAILROAD UNEMPLOYMENT LOANS MADE BEFORE OCTOBER 1, 1985.—So much of the amount transferred under paragraph (1) as is attributable to the basic rate under section 3321(c)(1)(A) of the Internal Revenue Code of 1954 shall be credited against, and operate to reduce, the outstanding balance of railroad unemployment loans made before October 1, 1985.

(B) TAXES ATTRIBUTABLE TO SURTAX RATE TO REDUCE RAILROAD UNEMPLOYMENT LOANS MADE AFTER SEPTEMBER 30, 1985.—So much of the amount transferred under paragraph (1) as is attributable to the surtax rate under section 3321(c)(1)(B) of such Code shall be credited against, and operate to reduce, the outstanding balance of railroad unemployment loans made after September 30, 1985.

(b) TRANSFERS MADE MONTHLY.—Transfers under subsection (a) shall be made at least monthly on the basis of estimates made by the Secretary of the Treasury of the amount of the additional railroad unemployment taxes received in the Treasury. Proper adjustments shall be made in the amount subsequently transferred to the extent prior estimates were in excess of or were less than the amounts required to be transferred.

(c) TRANSFERS TO RAILROAD UNEMPLOYMENT FUND AFTER LOANS REPAID.—If—

(1) the amount *described in subparagraph (A) or (B) of subsection (a)(2)* which (but for this subsection) would be transferred to the Railroad Retirement Account under subsection (a), exceeds—

(2) the outstanding balance of railroad unemployment loans (as of the time of such transfer) *against which the amount described in such subparagraph may be credited under such subparagraph,*

such transfer (to the extent it exceeds such outstanding balance) shall be made to the Railroad Unemployment Account.

(d) DEFINITIONS.—For purposes of this section—

(1) ADDITIONAL RAILROAD UNEMPLOYMENT TAXES.—The term "additional railroad unemployment taxes" means the taxes imposed by chapter 23A of the Internal Revenue Code of 1954.

(2) RAILROAD UNEMPLOYMENT ACCOUNT.—The term "Railroad Unemployment Account" means the railroad unemployment insurance account in the unemployment trust fund established pursuant to section 904 of the Social Security Act.

(3) RAILROAD UNEMPLOYMENT LOANS.—The term "railroad unemployment loans" means transfers under section 10(d) of the Railroad Unemployment Insurance Act from the Railroad Retirement Account to the Railroad Unemployment Account. The outstanding balance of such loans shall include any interest required to be paid under section 10(d).

SECTION 10 OF THE RAILROAD UNEMPLOYMENT INSURANCE ACT

RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT

SEC. 10. (a) * * *

* * * * * * *

(d) Whenever the Board finds at any time that the balance in the railroad unemployment insurance account will be insufficient to pay the benefits and refunds which it estimates are due, or will become due, under this Act, it shall request the Secretary of the Treasury to transfer from the Railroad Retirement Account to the credit of the railroad unemployment insurance account such moneys as the Board estimates would be necessary for the payment of such benefits and refunds, and the Secretary shall make transfer. Whenever the Board finds that the balance in the railroad unemployment insurance account, without regard to the amounts transferred pursuant to the next preceding sentence, is sufficient to pay such benefits and refunds, it shall request the Secretary of the Treasury to transfer from the railroad unemployment insurance account to the credit of the Railroad Retirement Account such moneys as in its judgment are not needed for the payment of such benefits and refunds, plus interest at a rate for each fiscal year equal to the average rate of interest borne by all special obligations held by the Railroad Retirement Account on the last day of the preceding fiscal year, rounded to the nearest multiple of one-eighth of 1 per centum, and the Secretary shall make such retransfer. In determining the balance in the railroad unemployment insurance account as of September 30 of any year pursuant to section 8(a) of this Act, any moneys transferred from the Railroad Retirement Account to the credit of the railroad unemployment insurance account which have not been retransferred as of such date from the latter account to the credit of the former, plus the interest accrued thereon to that date, shall be disregarded. [No transfer shall be made under this subsection from the Railroad Retirement Account after September 30, 1985, and no such transfer shall be made on or

before September 30, 1985, for purposes of paying benefits and refunds due after such date.]

* * * * * * *

SECTION 4006 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PREMIUM RATES

SEC. 4006. (a)(1) The corporation shall prescribe such schedules of premium rates and bases for the application of those rates as may be necessary to provide sufficient revenue to the fund for the corporation to carry out its functions under this title. The premium rates charged by the corporation for any period shall be uniform for all plans, other than multiemployer plans, insured by the corporation with respect to basic benefits guaranteed by it under section 4022 and shall be uniform for all multiemployer plans with respect to basic benefits guaranteed by it under section 4022 of this title. In establishing annual premiums with respect to plans, other than multiemployer plans, paragraphs (5) and (6) of this subsection (as in effect before the enactment of the Multiemployer Pension Plan Amendment Act of 1980) shall continue to apply.

(2) The corporation shall maintain separate schedules of preminum rates, and bases for the application of those rates, for—

(A) basic benefits guaranteed by it under section 4022 for single-employer plans,

(B) basic benefits guaranteed by it under section 4022A for multiemployer plans,

(C) nonbasic benefits guaranteed by it under section 4022 for single-employer plans,

(D) nonbasic benefits guaranteed by it under section 4022A for multiemployer plans, and

(E) reimbursements of uncollectible withdrawal liability under section 4222.

The corporation may revise such schedules whenever it determines that revised schedules are necessary. Except as provided in section 4022A(f), in order to place a revised schedule described in subparagraph (A) or (B) in effect, the corporation shall proceed in accordance with subsection (b)(1), and such schedule shall apply only to plan years beginning more than 30 days after the date on which the Congress approves such revised schedule by a concurent resolution.

(3)(A) Except as provided in subparagraph (C), the annual premium rate payable to the corporation by all plans for basic benefits guaranteed under this title is—

(i) in the case of a single-employer plan, for plan years beginning after December 31, 1977, an amount equal to $2.60 *($8.00 for plan years beginning after December 31, 1985, and before January 1, 1989)* for each individual who is a participant in such plan during the plan year;

(ii) in the case of a multiemployer plan, for the plan year within which the date of enactment of the Multiemployer Pension Plan Amendments Act of 1980 falls, an amount for each

individual who is a participant in such plan for such plan year equal to the sum of—

(I) 50 cents, multiplied by a fraction the numerator of which is the number of months in such year ending on or before such date and the denominator of which is 12, and

(II) $1.00, multiplied by a fraction equal to 1 minus the fraction determined under clause (i),

(iii) in the case of a multiemployer plan, for plan years beginning after the date of enactment of the Multiemployer Pension Plan Amendments Act of 1980, an amount equal to—

(I) $1.40 for each participant, for the first, second, third, and fourth plan years,

(II) $1.80 for each participant, for the fifth and sixth plan years,

(III) $2.20 for each participant, for the seventh and eighth plan years, and

(IV) $2.60 for each participant, for the ninth plan year, and for each succeeding plan year.

(B) The corporation may prescribe by regulation the extent to which the rate described in subparagraph (A)(i) applies more than once for any plan year to an individual participating in more than one plan maintained by the same employer, and the corporation may prescribe regulations under which the rate described in subparagraph (A)(iii) will not apply to the same participant in any multiemployer plan more than once for any plan year.

(C)(i) If the sum of—

(I) the amounts in any fund for basic benefits guaranteed for multiemployer plans, and

(II) the value of any assets held by the corporation for payment of basic benefits guaranteed for multiemployer plans,

is for any calendar year less than 2 times the amount of basic benefits guaranteed by the corporation under this title for multiemployer plans which were paid out of any such fund or assets during the preceding calendar year, the annual premium rates under subparagraph (A) shall be increased to the next highest premium level necessary to insure that such sum will be at least 2 times greater than such amount during the following calendar year.

(ii) If the board of directors of the corporation determines that an increase in the premium rates under subparagraph (A) is necessary to provide assistance to plans which are receiving assistance under section 4261 and to plans the board finds are reasonably likely to require such assistance, the board may order such increase in the premium rates.

(iii) [The maximum] *In the case of a multiemployer plan, the maximum* annual premium rate which may be established under this subparagraph is $2.60 for each participant.

(iv) [The provisions] *In the case of a multiemployer plan, the provisions* of this subparagraph shall not apply if the annual premium rate is increased to a level in excess of $2.60 per participant under any other provisions of this title.

V. DISSENTING AND ADDITIONAL DISSENTING VIEWS

A. DISSENTING VIEWS

We voted against reporting this bill. Although a $19 billion reduction in the federal deficit over three years is certainly a significant accomplishment, we are troubled by a number of elements of this package and its legislative context.

One major flaw is that the bill includes increases in federal spending. It expands spending in existing programs, it creates a new program, and it continue a program scheduled to "sunset." This extra spending must be paid for through higher taxes or greater reductions in other programs. We believe that it would be far better to hold the line on all programs so that the total amount of spending cuts could be credited against the $200 billion federal deficit.

For same of us, a second flaw is that the bill establishes a bad precedent by earmarking part of the excise tax on tobacco to pay, in effect, for the tobacco price support program. Some of us fear that this leads us down a path toward creation or expansion of special taxes, fees, and levies to facilitiate the continued growth of federal domestic spending at a time when we should continue to cut back on spending at every possible turn. In addition, the failure to sunset this increase after the three-year budget period, as one of us proposed in an amendment, eliminates the necessity to review the appropriateness of this tax level.

Expanded spending on existing programs would occur under this bill in the Aid to Families with Dependent Children (AFDC) program. The program currently permits states the option to provide benefits to unemployed two-parent families. About half the states are using this option. The bill would require all states to pay welfare benefits to two-parent families at a three-year cost of more than $400 million and a state cost of about two-thirds that amount, even though a dozen of those states have total unemployment rates less than the national average and low enough to make it likely that parents could find work readily. When the expanded program is fully implemented after 1989, it will cost around $300 million each year in federal outlays, a figure masked by the lower start-up costs contained in the three-year 1986–1988 estimates.

A second AFDC spending increase involves relaxing the quality control program which was established under the 1979 "Michel amendment" to combat welfare fraud, waste and inefficiency. Federal refusal to pay for more than three percent of welfare payments made in error has resulted in steady reductions in state error rates, although in 1981 over $1 billion still continued to be spent in excess of the amounts that properly should have been paid to recipients. Although the three-year estimate for easing up on the quality control program is $70 million, more than $200 million

a year in additional federal spending for "erroneous" welfare payments will be involved by Fiscal 1990 under this bill.

The bill creates a new $150 million program of federal grants to states for programs to deal with teenage pregnacy through prevention, counseling and services. Teenage childbearing is a troubling and serious problem. However, we are doubtful that throwing federal funds at the situation is the answer. This time of high federal deficits is not the time to begin such a dubious experiment.

The bill also continues a program—Trade Adjustment Assistance (TAA)—that was scheduled to end on September 30, 1985. Even though the program has been spending $100 million a year, it is listed by the Committee as having no cost for a three-year extension. This is possible because under House budget scoring procedures, continuation of a program does not count as additional spending, even though the program was scheduled to end. Depite the program's expansion to include workers and firms not previously covered and liberalization with regard to prior employment requirements, it is still listed as having no additional costs. In this case the reason is that we do not have the data to specify exactly what those costs will be. The Jobs Partnership Training Act provides the same job training the relocation allowances to displaced workers as will be continued under what could be argued is a duplicative TAA program. Under the current budget constraints, some of us feel we could do better with only one program, not two.

Notwithstanding these flaws, the bill makes a number of useful and justified deficit reductions. Most of us are generally in agreement with the amount of spending reduction allowed through the package of health amendments. The increase in customs personnel will improve customs efficiency, primarily in the commercial sector, while at the same time increasing customs revenues over the three years by $1.150 billion. Similarly, the additional IRS positions will improve the processing of tax returns and will result in a three-year revenue increase of $1.245 billion. The increase in premium paid by employers to the Pension Benefit Guaranty Corporation will begin to address the significant unfunded liability of the termination insurance program. Moreover, limiting the increase to only three years will help focus continued Congressional attention on the need for a comprehensive review of that program.

This legislation is ostensibly in the nature of a budget resolution bill. However, no budget resolution yet has been enacted for the upcoming fiscal year, so this bill therefore conforms, more or less, to the House-passed budget resolution. If House-Senate agreement is to be reached on a Congressional budget resolution, it will undoubtedly require further spending cuts beyond those originally proposed by the House. Thus, the speedy action to hurry this bill out of Committee seems premature to us. Necessary as these spending cuts and revenue increases may be, and despite the urgency of the federal deficit situation, we find that we can support neither the entire substance of this bill as it came out of our Committee nor the legislative context in which it was considered.

In situations such as this when dealing with many-faceted, multipurpose legislation, it is understandable that any sizable group of rational human beings will find absolute unanimity difficult, if not impossible, to achieve. In this particular case, the bill has at least a

little something we all can oppose. Some of us have stronger, or divergent, views on certain provisions of H.R. 3128. A few of us have elaborated on those differences in following, individualized statements. Others among us intend to express our supplemental thoughts in Floor remarks and in additional forums.

JOHN J. DUNCAN.
BILL ARCHER.
GUY VANDER JAGT.
PHILIP M. CRANE.
BILL FRENZEL.
RICHARD T. SCHULZE.
BILL GRADISON.
W. HENSON MOORE.
CARROLL A. CAMPBELL, Jr.
WILLIAM M. THOMAS.
HAL DAUB.
JUDD GREGG.

B. ADDITIONAL DISSENTING VIEWS

The Republican Members of the Committee on Ways and Means find it fiscally irresponsible to spend $600 million in new money in a bill that is supposed to be a deficit reduction measure. This money is being spent generally to liberalize the welfare program without regard for work or training of the recipients.

We have serious reservations about amending the AFDC quality control system because we believe that the proposed legislative changes have not taken into consideration the slow progress that has been made towards efficient management of the program. We fear that the changes that have been made by the exclusion of so-called technical errors will result in a more costly program with fewer safeguards for avoidable paperwork mistakes.

Further, we have now moved to a mandated unemployed-parent program. Under current law, the program is a state option and it should remain a state option.

This bill also creates a program to provide comprehensive and preventive services to teenage parents. This two year grant program to permit the state AFDC agencies to operate a two-part teenage pregnancy program may offer solutions to a complicated and difficult problem, however, the creation of a new program in a deficit reduction bill seems misplaced.

Within the teenage pregnancy bill, it is clearly the intent of the Committee on Ways and Means to not allow abortions to be performed or to include the counseling of individuals to have abortions excpet where the life of the mother would be endangered if the fetus were carried to term.

We understand that language in the Majority report states the anti-abortion amendment does not apply to current practices in law or regulations of Title IV or any other Social Security Act programs or other federally funded health and pubic assistance programs. We are concerned that this language may encourage the referral of pregnant teenagers to agencies that do counsel abortion and that the language may cause a circumvention of the intent of the bill language.

The intent of the bill language clearly is to stop abortion and the counseling of abortions, not to encourage the use of programs that may allow or counsel abortions.

Therefore, the report language should not encourage the referral to agencies that may counsel abortions except where the life of the mother would be endangered if the fetus were carried to term.

CARROLL A., CAMPBELL, Jr.,
BILL ARCHER.
PHILIP M. CRANE.
HAL DAUB.
BILL GRADISON.
JOHN J. DUNCAN.
WILLIAM M. THOMAS.
JUDD GREGG.

C. ADDITIONAL DISSENTING VIEWS

One of the important reasons that we are opposing this bill is the provisions that renew and expand the Trade Adjustment Assistance Program. Because of the program's past record of abuse, escalating costs and arbitrary administration, TAA was cut back dramatically in 1982 in ways that included tough cost controls. The worthwhile training needs associated with trade-related unemployment were shifted to the Jobs Partnership Training Act (JPTA) and TAA was set to expire at the end of this fiscal year. Now an attempt is being made to continue this duplicative program with additional provisions that once again could trigger uncontrollable cost increases.

The bill broadens TAA worker benefits coverage by allowing employees in firms that relocate overseas to qualify for TAA weekly allowances whether or not imports have increased or are likely to increase. In fact, import competition would not have to contribute in any way to the decision to move overseas. Workers in firms which supply export markets chiefly, or even exclusively, and have opted to serve those markets from foreign facilities now would be eligible for TAA. Also, workers in firms that shift certain product lines overseas in order to improve their world-wide competitiveness would now qualify for TAA even absent rising imports.

Such firms may be perfectly healthy, growing concerns that are competing effectively with both imports and domestic producers but have made sound business decisions to expand overseas. Firms really struggling against rising imports, but with no plans for overseas production, still would have to prove that *increasing* imports have "contributed importantly" to injury to the firm. Relocating firms would have to meet neither the increasing imports nor the "contributed importantly" injury tests. In effect, workers in firms that relocate overseas get more favorable treatment than those off from small firms that have only domestic production.

Given the proliferation of multinational firms, and the entitlement nature of TAA benefits, this new provision could add significant cost to the program. CBO noted that there were so many decisions made by individual firms about foreign operations that it would be impossible to measure the costs. Supporters of TAA have asked us to believe that this means there would be no significant cost increases. TAA eligibility would no longer be limited only to trade-impacted firms but would become a broad unemployment compensation program for firms that relocate all or part of their operation abroad. If the government picks up the tab for such a common business practice, how can there be no significant cost to the taxpayer?

The bill also expands the firm assistance part of the TAA program in two unfortunate ways. First, a firm could qualify for loans and technical assistance when the sales or production of an article

comprising only twenty-five percent of total sales or production of that firm has decreased absolutely. This would allow businesses that are impacted by imports in a very limited way, yet are healthy and profitable overall, to qualify for government assistance. Secondly, the bill limits the requirement that firms must share at least twenty-five percent of the cost of technical assistance, with the cost to the firm not coming until the implementation stage. This likely will result in firms requesting the free (taxpayer-paid) assistance without any commitment to use the results of the assistance.

These changes in the law obviously will create additional costs in a program that is fraught with inefficiencies and abuses. As of May 15, 1985, sixty percent of the dollar value and seventy-two percent of the total number of direct loans made under TAA prior to 1981 are *delinquent*. This is on top of "uncollectable" accounts totalling $131,469,000 that were written off over the years. The Commerce Department reports that subsequent loans are performing poorly with twenty-eight percent of the dollar value and forty-four percent of the number of direct loans already delinquent. An Inspector General study concludes that only 3.6 percent of firms entering the program are projected to improve or stablize employment or sales as a result of the TAA program.

The Inspector General report recommended abolition of the program, and we should take that advice. The program has never been effective but has frequently experienced cost overruns. Also, it has administered arbitrarily over the years, creating uncertainty and unfairness. Worthwhile training needs are covered under JPTA. Congress intended that the TAA program expire in FY 1985, and with so many more worthy and cost-effective programs competing for dollars in a deficit-ridden federal budget, we should put an end to programs like TAA that drain the budget yet have proved ineffective.

BILL ARCHER.
PHILIP M. CRANE.
BILL FRENZEL.
RICHARD T. SCHULZE.
BILL GRADISON.
WILLIAM M. THOMAS.
HAL DAUB.
JUDD GREGG.

D. ADDITIONAL DISSENTING VIEWS OF CONGRESSMAN GUY VANDER JAGT

Although I am generally in strong agreement with the Minority Views relative to Fiscal Year 1986 spending and revenue provisions, there are two important areas in which I have differing views.

First, I strongly oppose the extension of the physician fee freeze for nonparticipating physicians beyond the current 15-month freeze. This freeze creates an unnecessary additional differentiation between participating and nonparticipating physicians, and is an inappropriate signal to send to Medicare providers.

Secondly, I would like to express my support for the reauthorization of the Trade Adjustment Assistance program, particularly the Trade Adjustment Assistance program for firms. This program is a small, but necessary tool in our efforts to combat the huge trade deficits facing our country. The reauthorization of this modest program is the least that Congress can do to support the many firms and workers that are being harmed by the flood of imports entering our country.

GUY VANDER JAGT.

E. ADDITIONAL DISSENTING VIEWS FROM CONGRESSMAN PHILIP M. CRANE

I have voted against the reporting of this bill because I feel that there are some serious flaws in this legislation. I have already mentioned many of the flaws in the additional views submitted by my colleagues on the minority side of the Committee. However, there are two additional flaws in the bill to which I strongly object. There two major flaws are the increase in customs personnel and the increase in the number of Internal Revenue Service employees.

In this period of dangerously high budget deficits, there is a tremendous need to find ways to cut government spending in all areas of the budget. In regards to the U.S. Customs Service, the Ways and Means Committee voted to increase the number Customs Service employees above the amount the President judged was sufficient. Given the current budget deficit, I do not believe that it is a wise policy to increase the deficit by increasing funding for a program beyond what the President decided was necessary to cut the deficit.

In regards to the increase in the number of IRS employees, again, this is a dangerous increase for a period in which huge deficits are rampant. We must get deficits under control. The answer is not to increase the number of IRS employees beyond what the President's deficit-reducing budget considers adequate. To increase the number of IRS employees in an attempt to increase the tax intake from the American people is a tacit acceptance of a tax increase. I do not believe we should continue to squeeze tax money out of an already over-taxed populace as a means to reduce the deficit. If the budget deficit is to be decreased, then spending cuts must be implemented.

These are the two main objections I have in which I diverge from the objections of my colleagues on the minority side. Without the removal of these sections, along with the removal of the sections I have already listed along with my colleagues, I cannot accept the bill.

PHILIP M. CRANE.

F. ADDITIONAL DISSENTING VIEWS OF BILL FRENZEL

H.R. 3128

The attached dissenting views which I have signed do not express with enough vigor my opposition to H.R. 3128.

This bill not only creates new welfare programs, raises spending, funds redundant or obsolete programs, and raises taxes. Much worse, it misses another opportunty to enact real, permanent spending reductions. Again, the Committee has been tested, and has failed.

Title I, on Medicare, is the section of wasted opportunities. Title II funds Trade Adjustment Assistance which duplicates existing job training services, and it also raises Customs' "user fees" about 300% to $200 million. No matter how those fees are perfumed they are new taxes.

Title III, the welfare section, is where we find a whole new program, and much extra unnecessary spending. In Title IV, dealing with railroad unemployment, the Committee assessed another $200 million in new taxes, and used it to finance extra welfare spending.

Title V, Revenue Provisions, contains the controversial cigarette tax extension. Majority Members diverted (read spent) 1¢ of the tax to tobacco producers. That's a $200 million annual gift from the taxpayers to tobacco growers.

Altogether, the bill is best described as another lost chance to some real money. It should be defeated, and the Committee sent back to the drawing board to do better.

BILL FRENZEL.

G. ADDITIONAL DISSENTING VIEWS OF HON. W. HENSON MOORE

In 1983, we enacted the most significant medicare change since the beginning of the program in 1965. In one bold, and long overdue, stroke we changed the basis for the payment to hospitals from an inflationary cost/based system to a prospectively-determined rate of payment that rewards efficiency and economy. The response to that change has been beyond our most optimistic expectations. The 1983 legislation provided an orderly transition to a national payment rate to allow time for hospitals to curtail their past budget-busting behavior. This transition gives hospitals three years to move away from their hospital specific costs towards a fully phased-in national payment system in FY 87. Unfortunately, in my view, the Committee included a provision to delay the transition by maintaining the current 50% hospital specific/50% regional-national rate for another year.

We all heard the crises of woe last year when the system moved to the current 50/50 rate and efforts were made then for a one year freeze in the phase in. We defeated those efforts to stop the progress of the system. We should do so again this year. If we bow to the pressures of high cost hospitals now, we will merely be sending signals that they can continue to operate inefficiently. Those hospitals that are contributing most significantly to the escalation of the cost of health care will be back at our door step next year asking for yet another freeze or some sort of exception to the prospective payment system.

Last year when high cost hospitals asked Congress to not move forward with the prospective payments system they gave us tales of impending financial disaster in the industry. According to data from the American Hospital Association, total hospital expenses rose by only 4.5% in 1984 as compared with 10.2% in 1983, while cost per case growth declined nearly 3%, admissions declined by 3.7%, and the average length of stay dropped 4.3%. Notwithstanding the decrease utilization, revenue margins rose from 5.1% to 6.2% over the period, thereby providing the best bottom line the industry has had in over 20 years. Most importantly, these changes have occurred without any convincing evidence that the quality of care has suffered.

While there are many factors at play in this remarkable performance, most experts would agree that the new medicare prospective payment system was, and is, the driving force. To stop the implementation of the system at this point, even for only a year, will send signals to high cost hospitals that we are not serious about a market oriented system for containing health care cost. Instead, hospitals will have the incentive to drift it back toward their excessive and expensive old habits. We can't affort to let this happen.

I offer a compromise amendment in the Ways and Means Committee to allow the prospective payment system to still move forward, but at a slower pace. That amendment was defeated by only two votes. I am hopeful that we will have a second opportunity on the House floor.

My amendment would allow one additional year for the transition to phase-in. Under my amendment, in FY 86, hospital payments would be calculated on a 60% regional-national rate/40% hospital specific rate. In FY 87, the calculation would move forward to 80% regional-national/20% hospital specific, and in FY 88, the system would be fully phased in at 100% national rate. This amendment would give high cost hospitals an opportuntiy to further adjust to the positive cost pressures of the prospective payment system, while still sending signals that Congress is serious about containing health care costs.

Clearly, the prospective payment system is not without its faults, but rather than delay its implementation, we should endeavor to "fine tune" the system as we go along. In this regard the Committee is to be commended for approving an improved wage index as well as an adjustment for hospitals that serve a disproportionate share of low income patients. These adjustments will aid considerably in addressing the concerns being expressed by those who are calling for the transition delay.

I am convinced, however, that the Committee's action to maintain for another year the current 50/50 payment mix would erode the progress we have made in getting hosptial costs under control. Accordingly, I must take strong exception to that action, and I intend to work for a floor amendment to allow the system to go forward next year at a 60% regional-national/40% hospital-specific rate. I encourage my colleagues to support this effort.

I am also sorely disappointed that the Committee did not use this opportunity to enact sound structural chances to secure the future of the medicare trust fund. By all informed accounts, the trust fund will not remain solvent through this century. We had a unique opportunity to enact comprehensive structural changes in physician reimbursement, capital cost payments and program operations and lost it.

Instead the Committee chose the easy way out to achieve budget savings by singling out specific interests for one-time freezes or payment limitations and adding new taxes by including newly hired state and local employees under medicare. Of the $10.3 billion in savings claimed from the health provisions, about 80% comes from temporary program changes such as freezes or limitations on hospital payments, physician payments, durable medical equipment and indirect medical education. Another 5% comes from the increased taxes. Less than 15% comes from permanent structural changes in payment policy. We have not made the permanent

programmatic changes needed to render medicare solvent. We will someday be forced to fight tougher political battles when we are at the brink of insolvency and have to take more drastic steps without the benefit of a long phase in period as we had available now.

I am most distressed that we have not taken advantage of this unique opportunity.

W. HENSON MOORE.

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